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SOURCE
BOOK
OF
HEALTH
INSURANCE
DATA



1989

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PREFACE

The *Source Book of Health Insurance Data*, containing the latest statistics available on private health insurance, and much more, has been published by the Health Insurance Association of America every year since 1960.

This 1989 edition is an expanded one, with more utilization data and many more graphs than we have published before. This year, we return to our pre-1986 practice of issuing a complete version of the *Source Book* every year.

We hope the *Source Book* proves to be an increasingly valuable reference for writers, editors, researchers, educators, government leaders, hospital and medical professionals, business associations and others interested in the health care industry.

A handwritten signature in dark ink, appearing to read 'Carl J. Schramm', with a long, sweeping horizontal line extending to the right.

Carl J. Schramm

President, Health Insurance Association of America

FOREWORD

The 1989 edition of the *Source Book of Health Insurance Data* is a statistical report of private health insurance in the United States. The book is published annually by the Policy Development and Research Department of the Health Insurance Association of America on behalf of its member companies.

This edition of the *Source Book* provides the latest available data on the major forms of health insurance coverage, medical care costs, utilization of the nation's medical facilities and national morbidity trends. The data are compiled from reports of insurance companies, government agencies, hospital and medical associations and other health insurance plans.

A handwritten signature in cursive script that reads "Richard E. Curtis".

Richard E. Curtis

Director

Policy Development and Research

For information call:

A.F. Minor

Consumer Studies Coordinator

(202) 223-7845

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KEY HEALTH INSURANCE STATISTICS

	1984	1985	1986	1987	% change 86-87
Number of persons with Private Health Insurance in the United States*** (000 omitted)					
Total population	233,445	235,520	238,197	239,209	0.4%
Persons covered	202,107	204,235	204,419	205,531	0.5%
Private health insurance	177,418	180,089	180,060	181,125	0.6%
Employer related	144,321	147,086	145,784	146,658	0.6%
Persons not covered	31,338	31,285	33,778	33,878	0.3%
Health Insurance Claims Payments in the United States* (000,000 omitted)					
Insurance companies	\$ 55,980	\$ 59,962	\$ 64,303	\$ 69,167	7.6%
Blue Cross-Blue Shield	35,744	37,540	40,587	44,525	9.7%
Other plans	26,022	32,534	36,800	47,300	28.5%
Total	\$ 107,522	\$ 117,609	\$ 128,502	\$ 139,100	8.2%
Private Health Insurance payment by category of service** (000,000,000 omitted)					
Hospital care	\$ 56.4	\$ 59.3	\$ 64.4	\$ 71.9	11.7%
Physicians' services	33.3	36.8	40.2	44.6	10.9%
Dentists' services	8.2	9.3	10.8	12.1	12.0%
Drugs & sundries	3.6	4.0	4.2	4.7	11.9%
Eyeglasses & appliances	0.8	0.9	1.0	1.1	10.0%
Nursing home care	0.3	0.3	0.3	0.4	33.3%
Other prof services	2.4	2.8	3.7	4.3	16.2%
Program admin and					
Cost private health insurance	16.6	19.8	17.8	18.7	5.1%
Total	\$ 121.5	\$ 133.3	\$ 142.4	\$ 157.8	10.8%
Per Capita amount of NHE by source of funds**					
Total per capita	\$ 1,587	\$ 1,696	\$ 1,827	\$ 1,987	8.8%
Private funds	935	987	1,069	1,164	8.9%
Public funds	652	708	757	824	8.9%
Health Care Costs** (000,000,000 omitted)					
NHE	\$ 388.5	\$ 419.0	\$ 455.7	\$ 500.3	9.8%
Percent of GNP	10.3	10.4	10.7	11.1	3.7%
Total personal health care	340.1	368.3	401.6	442.6	10.2%
Private health insurance	105.3	112.0	124.6	139.1	11.6%
Medicare & Medicaid	99.4	109.6	118.2	130.6	10.5%

SOURCE: * Health Insurance Association of America.

** Health Care Financing Administration, National Health Expenditure Accounts.

*** United States Bureau of the Census, Current Population Survey.



Chapter 1

PRIVATE HEALTH INSURANCE COVERAGE

At the end of 1987, more than 205 million Americans, 86 percent of the civilian noninstitutional population, were protected by one or more forms of health care coverage. (Table 1.1)

More than 181 million persons were covered by private health insurance with commercial insurance companies, Blue Cross and Blue Shield plans, self-funded employer plans and prepayment plans such as health maintenance organizations (HMOs).

Most commercial health insurance companies provide two basic categories of coverage: medical expense insurance and disability income insurance. Medical expense insurance provides broad benefits that can cover virtually all expenses connected with hospital and medical care and related services. Disability income insurance provides periodic payments when the insured is unable to work as a result of sickness or injury.

The Blue Cross and Blue Shield Association coordinates the Blue Cross and Blue Shield plans of the nation. These nonprofit membership plans service state and regional areas and offer both individual and group health insurance coverage.

Health care coverage is also provided through HMOs that provide comprehensive health care services to their members for a fixed periodic payment. In such plans a group of physicians, surgeons, dentists or optometrists furnish needed care as specified in the contract provided to subscribers. InterStudy, in a June 1988 report, indicated that the national growth in HMO membership quintupled in just over a decade, rising from 6 million people in 1976 to nearly 30 million members in a total of 653 HMOs in 1987.

Plans administered by employers, labor unions, fraternal societies, communities, and by rural and consumer health cooperatives often make health insurance available to specific groups of people who are not covered under conventional plans.

In 1987, 55 percent of insurance company group coverage was represented by administrative service only (ASO) arrangements and minimum premium plans

(MPPs). Under ASO arrangements, corporations and other organizations establish self-funded health plans and pay insurance carriers or private organizations a fee to process claims. Under MPPs, employers self-fund their plans yet insure a certain level of large, unpredictable claims.

Persons with Specified Health Insurance Programs
as a Percent of All Persons with Private Insurance, 1987
(Total covered 181,125,000)

Persons covered	Types of Insurance		
	Major medical	Dental	Long-term disability
% covered by type	86.4%	52.8%	13.2%

SOURCE: Health Insurance Association of America.

◆ Hospital/Medical Insurance

Hospital/medical expense coverage provides specific benefits for daily hospital room and board and usual hospital services and supplies during hospital confinements. Room and board benefits are usually stated in one of two ways. One is reimbursement for the actual room and board charge up to a specified maximum amount per day for hospital confinement. The second provides a service-type benefit that equals the semiprivate room and board charge of the hospital.

Hospital/medical coverage may be provided in one of three ways: (1) a health insurance policy often sold in combination with a surgical expense policy that provides benefits for both surgical operations and doctor's in-hospital visits; (2) a major medical policy that provides broad and substantial coverage for many types of medical expenses; or (3) a hospital indemnity policy.

Hospital indemnity coverage is issued only to individuals and provides a stipulated daily, weekly or monthly indemnity during hospital confinement. The money is payable without regard to the actual expense of hospital confinement or the existence of other insurance coverage.

◆ Major Medical Expense Insurance

Major medical expense insurance, introduced nationally by insurance companies in 1951, has grown rapidly. Major medical coverage provides broad and substantial protection for large, unpredictable medical expenses. It covers a wide range of medical charges with few internal limits and a high overall maximum benefit.

Basically, there are two types of major medical plans. One supplements basic hospital-surgical-physician's expense insurance programs and the other provides comprehensive protection where both basic coverage and extended health care benefits are integrated.

The majority of major medical policies whether written for individuals or under group plans are subject to some form of deductible and coinsurance payments by the insured.

◆ Disability Income Protection

Disability income coverage provides for the partial replacement of income lost by employees as the result of an accident, illness or pregnancy. Generally, disability income policies are divided into those that provide benefits for up to two years (short-term) and those that provide benefits for a longer period, usually for at least five years, to age 65 or for life (long-term).

When provided on a group basis, the benefits are usually integrated with benefits from Social Security and other public programs. The total level of benefits from these sources is generally set at a level that does not exceed 60 percent of salary.

Individual disability income policies usually provide a fixed dollar amount of coverage. This amount may be greater for those who are turned down by Social Security. Individual disability income policies take many forms and may be designed to fit the special needs of the individual policy owner.

◆ Dental Expense Insurance

Dental expense insurance, generally available through insurance company group plans, prepayment plans and dental service corporations, provides reimbursement for expenses of dental service and supplies and encourages preventive care. The coverage normally provides for oral examinations (including X-rays and cleaning), fillings, extractions, inlays, bridgework and dentures, as well as oral surgery, root canal therapy and orthodontics.

◆ Self-Insurance

The continuing growth in the number of insurance plans where the employer or union assumes all or part of the responsibility for paying claims made the nation's employers a principal private sector bearer of the financial risks of illness and non-job-related injury in 1987.

There are two basic types of self-insured plans. In a totally self-insured plan, the employer assumes all the risk for paying claims. Under an MPP, the employer

pays up to a stop-loss threshold, then an insurer pays or shares in the payment of additional claims. The administration of a self-insured plan includes claims processing, actuarial estimation of plan costs and utilization review, which are the responsibility of the employer, an insurance carrier, a third-party administrator (TPA) or a combination of all three.

These plans, like fully insured plans, typically cover medical expenses under basic coverage only, major medical coverage only or basic plus major medical coverage. Commercial insurance company and Blue Cross and Blue Shield plans provide employees with basic plus major medical coverage.

The majority of self-insured plans are freestanding major medical plans and do not contain a basic hospital benefit that provides full and unlimited coverage for hospital-related charges. In most self-insured plans, covered services are subject to a deductible and coinsurance.

The growth of self-insurance has been encouraged by the fact that self-insured plans do not pay state premium taxes and do not have to meet state minimum benefit mandates.

If employers decide in the future that self-insured plans with the usual cost-containment benefits, such as second opinion for surgery and hospice coverage, allow them to control costs and to exercise greater control over their health plans, the movement toward self-insurance can be expected to continue.

◆The Uninsured Population

Recent years have witnessed dramatic growth in the uninsured population. Based on Current Population Survey estimates, the number of uninsured in this country grew from 28.4 million in 1979 to 36.8 million in 1986, an increase of almost 30 percent.

The Uninsured Population 1986 (000,000 omitted)

	<u>Total population</u>	<u>Number insured</u>	<u>Number uninsured</u>	<u>Percent uninsured</u>
Total population	238.7	201.5	37.1	15.6
Under 65 population	210.6	173.8	36.8	17.5

SOURCE: Congressional Research Service (CRS) based on the Current Population Survey (CPS).

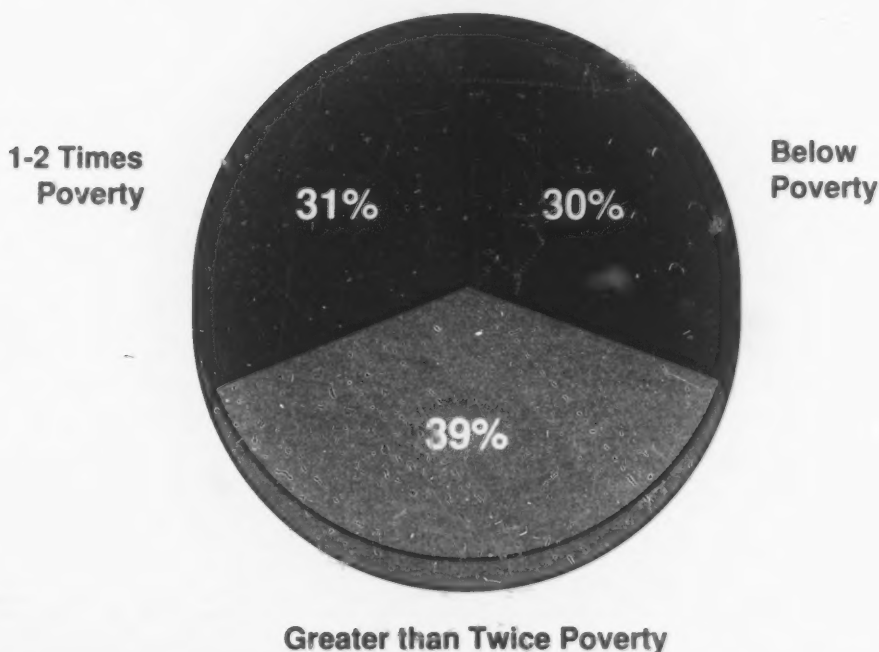
The characteristics of the uninsured population defy any given stereotype. Contrary to intuition, the uninsured are not predominately poor and unemployed. The Employee Benefit Research Institute (EBRI), in a report entitled *Uninsured in the United States: The Nonelderly Population without Health Insurance, 1987*,

estimates that nearly one-half of the uninsured are workers, one-third are children under age 17 and only 17 percent are nonworking adults.

A number of factors are responsible for growth in the uninsured population including the economic downturn in the early 1980s and its effect on employment; erosion of the Medicaid program's coverage of the poor; demographic shifts; to a small extent, shifts of workers to industries less likely to offer health insurance; and finally, increased health care insurance costs which have outpaced the growth in incomes.

Several recent studies indicate that the uninsured span all income groups but live predominantly in low- and middle-income families. Thirty percent of the uninsured have family incomes that fall below the federal poverty level, 31 percent have incomes between one and two times poverty and the remaining 39 percent have incomes that are greater than twice poverty. In 1986, the federal poverty standard for a family of four was \$11,203.

Nonelderly Uninsured by Family Income 1987



SOURCE: Employee Benefit Research Institute, *Uninsured in the United States: The Nonelderly Population Without Health Insurance*, 1987.

A Continuing Problem

Large numbers of uninsured pose a major national problem for a variety of reasons. First, there is growing evidence that uninsured persons have difficulty in

accessing the health care system and if and when they do, it is often too late or more costly. Second, this care is borne indirectly by providers and insurers through "unsponsored care" or cost shifting. It has been estimated the uninsured are responsible for as much as 70 percent of unsponsored care.

In 1988, an HIAA survey of employers found cost to be the most important reason employers gave for not offering coverage. Other important reasons indicated were insufficient profits and no employee interest.

Table 1.1

The Status of Health Insurance Coverage in the United States, Selected Years (000 omitted)

Characteristics	1984	1985	1986	1987
Total population	233,455	235,520	238,197	239,209
THE INSURED				
Total covered	202,107	204,235	204,419	205,531
Percent of total population	86.6%	86.7%	85.8%	85.9%
Age				
0 to 64	175,579	177,167	176,900	177,487
65 and over	26,528	27,068	27,517	27,944
Race				
White	174,239	175,243	175,228	176,201
Black	22,134	22,995	23,094	23,243
Hispanic	10,054	10,353	12,962	13,367
PEOPLE COVERED BY PRIVATE INSURANCE				
Total	177,418	180,089	180,060	181,125
Percent of total population	76.0%	76.5%	75.6%	75.7%
Age				
0 to 64 years	158,057	159,583	159,328	159,784
65 and over	19,360	20,506	20,733	21,341
Race				
White	157,722	159,336	158,525	159,198
Black	15,267	15,884	16,328	16,927
Hispanic	7,580	7,824	9,761	9,957

NOTE: Hispanic may contain persons of any race.

NOTE: Totals may not add due to rounding or duplication.

SOURCE: Current Population Survey, Bureau of the Census.

Table 1.2

The Insured and the Uninsured by State, 1986 (000 omitted)
(Under 65 years of age)

Region and State	Total population	Total private	Employer-related private	Public	Uninsured
Total	208,023	152,898	136,123	24,883	37,027
New England	10,916	8,805	7,939	990	1,333
Maine	953	732	635	105	145
New Hampshire	883	745	689	*	101
Vermont	461	359	326	*	69
Massachusetts	5,085	4,095	3,688	513	605
Rhode Island	824	700	633	83	69
Connecticut	2,710	2,173	1,969	289	345
Middle Atlantic	31,893	24,405	22,071	3,675	4,567
New York	15,286	11,052	10,030	2,008	2,556
New Jersey	6,682	5,393	4,858	585	825
Pennsylvania	9,925	7,960	7,183	1,082	1,185
East-North Central	36,378	27,956	25,259	4,488	5,133
Ohio	9,356	7,153	6,499	1,036	1,409
Indiana	4,654	3,630	3,258	342	833
Illinois	10,093	7,606	6,838	1,333	1,481
Michigan	8,133	6,199	5,638	1,306	965
Wisconsin	4,143	3,367	3,026	470	444
West-North Central	15,209	11,944	10,000	1,544	2,122
Minnesota	3,670	2,931	2,418	475	389
Iowa	2,532	2,035	1,640	280	295
Missouri	4,391	3,328	2,941	471	714
North Dakota	548	443	325	*	87
South Dakota	595	463	349	*	103
Nebraska	1,383	1,069	897	130	234
Kansas	2,090	1,673	1,430	188	299
South Atlantic	34,639	25,561	22,717	3,892	6,393
Delaware	553	421	387	*	99
Maryland	3,972	3,133	2,869	350	617
District of Columbia	526	365	329	*	112
Virginia	4,799	3,808	3,466	626	622
West Virginia	1,621	1,106	959	297	295
North Carolina	5,364	3,997	3,574	533	985
South Carolina	2,840	2,092	1,888	406	468
Georgia	5,311	3,891	3,519	677	954
Florida	9,653	6,767	5,725	1,004	2,242
East-South Central	12,973	8,658	7,665	1,800	2,950
Kentucky	3,139	2,151	1,895	448	659
Tennessee	4,010	2,725	2,429	620	826
Alabama	3,575	2,378	2,144	430	859
Mississippi	2,249	1,404	1,197	303	606

Continued

West-South Central	23,290	15,494	13,827	2,656	5,861
Arkansas	2,007	1,312	1,153	295	487
Louisiana	3,920	2,548	2,234	599	904
Oklahoma	2,793	1,943	1,690	332	636
Texas	14,569	9,691	8,751	1,430	3,833
Mountain	11,354	8,351	7,191	1,085	2,242
Montana	715	525	408	88	134
Idaho	863	626	524	*	196
Wyoming	441	329	283	*	78
Colorado	2,769	2,052	1,778	384	450
New Mexico	1,249	827	670	142	325
Arizona	2,895	2,129	1,832	221	651
Utah	1,546	1,181	1,080	155	253
Nevada	878	682	617	95	154
Pacific	31,369	21,705	19,454	4,263	6,427
Washington	3,808	2,739	2,394	656	603
Oregon	2,401	1,753	1,573	233	478
California	23,874	16,217	14,629	3,270	5,142
Alaska	453	324	271	*	97
Hawaii	833	672	587	104	107

SOURCE: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

* Number is too small to be statistically reliable.

Table 1.3

Percentage of Population Insured and Uninsured by Work Status, Age and Sex, and Earnings, 1986

Work Status, Sex and Age	Total insured	Total private	Employer-related private	Public	Uninsured
All Workers	84.6	81.6	74.7	6.0	15.4
Men	83.5	81.2	74.6	5.0	16.5
Women	85.9	82.0	74.7	7.2	14.1
18-20	75.6	69.4	61.8	10.0	24.4
21-24	68.5	64.5	58.0	6.1	31.5
25-29	82.2	79.0	73.9	5.3	17.8
30-44	88.4	85.6	80.3	5.2	11.6
45-54	89.9	87.8	80.4	6.1	10.1
55+	89.3	87.0	72.5	7.1	10.7
Personal Earnings					
Total	84.6	81.6	74.7	6.0	15.4
\$10,000	71.0	64.5	51.7	9.9	29.0
\$10,000-19,999	89.0	87.7	83.4	4.3	11.0
\$20,000-39,999	96.1	95.5	93.1	3.2	3.9
\$40,000+	97.5	97.2	94.9	2.6	2.5

SOURCE: Employee Benefit Research Institute tabulations of the March 1987 Current Population Survey.

Chapter 2

HEALTH INSURANCE CLAIMS

In 1987, private health insurers in the United States paid a total of \$139.1 billion for medical care or disability claims (Table 2.1), an 8.2 percent increase over 1986, and more than three times the amount paid 10 years earlier. The increase was primarily due to the rising cost of medical care, expansion of coverage under health insurance policies and higher utilization of these policies by those insured.

Commercial insurance companies paid nearly one half (\$69.2 billion) of the total \$139.1 billion in health insurance claims. This represents a 7.6 percent increase over the \$64.3 billion paid in 1986. Blue Cross and Blue Shield plans, which usually make direct payment for covered services of the participating hospital or physician, paid over \$44 billion in benefits in 1987. Self-insured and HMO plans recorded \$47.3 billion in paid claims for the same period.

Hospital and medical expense claims (Table 2.2), including payments under hospital, surgical, physician expense and major medical insurance, totaled \$51.7 billion in 1987, an increase of 7.6 percent over 1986. Dental claim payments totaled \$5.5 billion in 1987.

Long-term care claims payments rose from \$5 million in 1986 to \$12 million in 1987, reflecting the first two years a large group of insurance companies offered this coverage. Loss of income claims, including both short-term and long-term disability, cost insurance companies over \$4 billion in 1987. Policies purchased to supplement Medicare coverage provided \$1.5 billion to claimants.

In the 1970s many insurance companies began to use financing arrangements such as administrative service only (ASO) and minimum premium plans (MPPs) for their group health business. Only 24.8 percent of the total group claims payments (Table 2.3) came from ASOs and MPPs in 1980. By 1987, insurance companies paid policyholders more than 51 percent of the total group claims of \$63.2 billion through these two types of arrangements.

Reimbursement for health claims is provided primarily through indemnity payments by insurance companies to the insured person for his or her covered expenses. Payment may also be made directly to the provider of care through an assignment of claims benefits.

A survey of the 20 leading writers of health insurance conducted by HIAA in July 1988 indicated a group underwriting loss of 3.9 percent, continuing the deterioration in underwriting performance begun in 1985. Individual health insurance also showed a downward trend with a 6.2 percent underwriting loss. 1987 was a year of record losses for the health insurance industry."

The survey represents companies that write approximately 55 percent of the total group health insurance premiums and approximately 35 percent of the total individual health insurance premiums written by commercial insurance companies in the United States.

The dollar totals noted in this chapter refer to incurred claims. Premium figures reported in Chapter 3 are on an earned basis for the calendar year in order to reflect a true picture of premiums for the year.

Additions to claim reserves for persons already disabled are extracted from current year premiums but not reflected in the claims payments. These claim reserves will be used to make future disability income payments under the contracts.

Leading Health Insurers (Net underwriting results, 1976 - 1987)

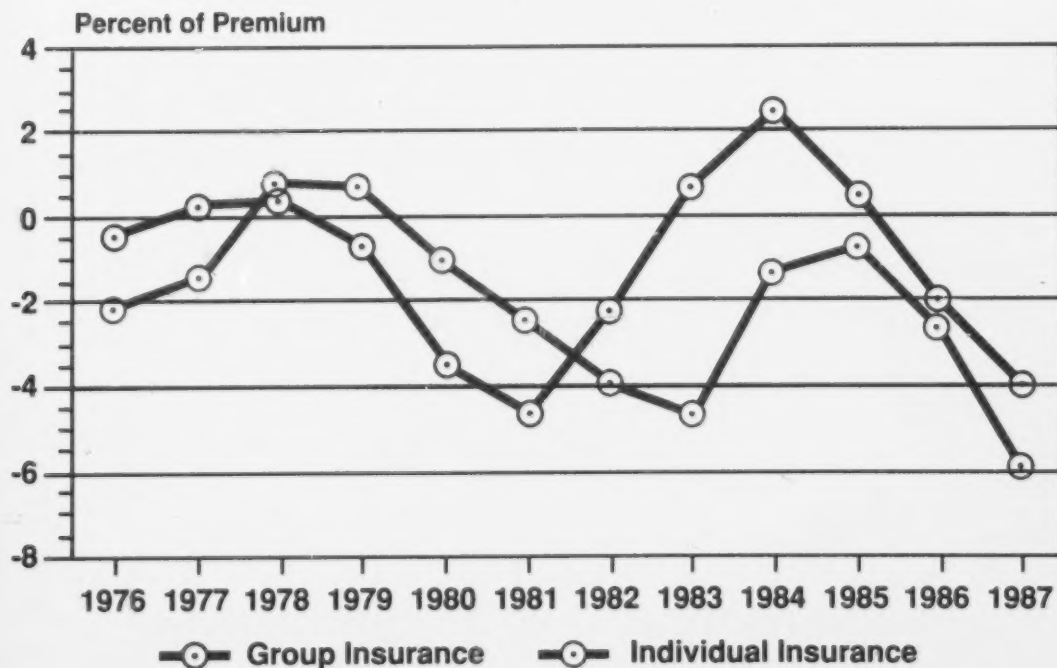


Table 2.1

Health Insurance Claims Payments by Type of Insurer in the United States (000,000 omitted)

Year	Insurance companies	Blue Cross-Blue Shield	Self-insured & HMO plans	Total
1950	\$ 755	\$ 590	NA	\$ 1,347
1955	1,785	1,357	NA	3,142
1960	3,069	2,607	NA	5,676
1965	5,160	4,464	NA	9,624
1970	9,089	8,088	NA	17,177
1975	16,470	16,932	NA	32,081
1978	26,352	19,465	\$ 10,555	55,487
1979	31,692	21,724	13,351	65,449
1980	37,002	25,467	16,239	76,320
1981	41,622	29,209	18,945	85,884
1982	49,159	32,144	21,577	97,135
1983	51,665	34,398	24,055	104,085
1984	55,980	35,744	26,022	107,522
1985	59,962	37,540	32,534	117,609
1986	64,303	40,587	36,800	128,502
1987	69,167	44,525	47,300	139,100

SOURCE: Health Insurance Association of America.

Table 2.2

Group Health Claims Payments of Insurance Companies in the United States (000,000 omitted)

Year	Total group	Hospital/ Medical	Dental	Long-term care	Medicare supplement	Loss of income
1945	\$ 139	NA	NA	NA	NA	NA
1950	438	NA	NA	NA	NA	NA
1955	1,252	NA	NA	NA	NA	NA
1960	2,350	\$ 1,809	*	NA	NA	\$ 839
1965	4,000	3,321	*	NA	NA	1,047
1970	7,476	6,043	\$ 140	NA	NA	1,816
1975	14,191	11,607	599	NA	NA	2,707
1976	17,795	14,425	1,187	NA	NA	2,914
1977	19,479	15,683	1,452	NA	NA	3,109
1978	22,868	18,696†	1,771	NA	NA	2,401
1979	27,934	22,159†	2,185	NA	NA	3,590
1980	33,002	25,829	2,795	NA	\$ 66	4,312
1981	37,691	29,892	3,474	NA	165	4,160
1982	44,202	35,942	3,984	NA	132	4,144
1983	46,890	38,574	4,372	NA	75	3,869
1984	50,305	41,084	4,913	NA	401	3,907
1985	53,669	43,867	5,292	NA	473	4,037
1986	58,926	48,088	5,262	\$ 5	1,547	4,024
1987	63,232	51,747	5,545	12	1,504	4,424

SOURCE: Health Insurance Association of America.

* Number is too small to be statistically reliable.

† Medicare Supplement is included in Hospital/Medical for these years.

Table 2.3

Group Health Claims Payments of Insurance Companies in the United States by Type of Financing Arrangement
(000,000 omitted)

Year	Total group payment	Fully Insured		ASO		MPP	
		Hospital/Medical	Loss of income	Hospital/Medical	Loss of income	Hospital/Medical	Loss of income
1945	\$ 139	NA	NA	NA	NA	NA	NA
1950	438	NA	NA	NA	NA	NA	NA
1955	1,252	NA	NA	NA	NA	NA	NA
1960	2,350	\$ 1,809	NA	NA	NA	NA	NA
1965	4,000	3,321	NA	NA	NA	NA	NA
1970	7,476	6,043	NA	NA	NA	NA	NA
1975	14,191	11,607	NA	NA	NA	NA	NA
1978	22,868	18,696†	\$1,771†	NA	NA	NA	NA
1979	27,934	22,159†	2,185†	NA	NA	NA	NA
1980	33,859	21,694	3,781	\$ 2,223	\$164	\$ 5,630	\$367
1981	37,691	19,751	3,183	3,621	269	10,160	707
1982	44,202	21,665	3,005	5,364	373	13,029	766
1983	46,890	22,840	2,921	5,702	240	14,479	708
1984	50,305	20,647	2,676	9,699	413	16,052	818
1985	53,669	21,507	2,783	11,820	486	16,305	768
1986	58,926	23,066	2,692	14,133	720	17,703	612
1987	63,232	27,775	2,989	16,124	813	14,909	622

SOURCE: Health Insurance Association of America.

†Breakout by financing arrangement not available.

Table 2.4

Individual Health Insurance Claims Payments of Insurance Companies in the United States (000,000 omitted)

Year	Total individual	Hospital/Medical	Long-term care	Loss of income
1978	\$ 3,484	\$ 2,480	NA	\$ 1,004
1979	3,758	2,644	NA	1,114
1980	4,000	2,970	NA	1,030
1981	3,931	2,935	NA	996
1982	4,957	3,572	NA	1,385
1983	4,775	3,751	NA	1,024
1984	5,675	4,422	NA	1,253
1985	6,293	4,696	NA	1,597
1986	5,377	3,789	\$11	1,577
1987	5,935	4,003	99	1,833

SOURCE: Health Insurance Association of America.

Table 2.5

Underwriting Results for Insurance Companies and Blue Cross and Blue Shield, 1984-1987

INSURANCE COMPANIES

Number of companies Year reported	(702) 1984	(677) 1985	(636) 1986	(646) 1987
Underwriting Loss/Gain*	(\$108,235)	(\$389,153)	(\$1,952,098)	(\$3,629,118)

BLUE CROSS AND BLUE SHIELD

Number of organizations Year reported	(60) 1984	(55) 1985	(54) 1986	(47) 1987
Underwriting Loss/Gain*	\$2,069,711	\$1,578,025	\$150,893	(\$1,907,952)

*Includes expenses incurred.

SOURCE: National Underwriter Company, Argus Health Charts, various years.

NOTE: The number of companies providing claims data for Argus Health Charts does not represent the same number of companies represented by NIAA data reported in tables in Chapters 2 and 3 of this book.

Chapter 3

HEALTH INSURANCE PREMIUMS

In 1987, health insurance premium income of all private insuring organizations was \$157.8 billion. Americans spent the equivalent of 4.92 percent of disposable personal income (personal income less personal taxes) in 1987 for health insurance premiums, compared with 4.75 percent in 1986.

Insurance company premiums reported in Tables 3.1 and 3.2 are on an earned basis for the calendar year (earned premiums are defined as the calendar-year portion of premiums for which the protection of the policy has been provided).

Insurance companies earned \$80.3 billion in premiums in 1987; 88 percent of these premium dollars were for group insurance coverage.

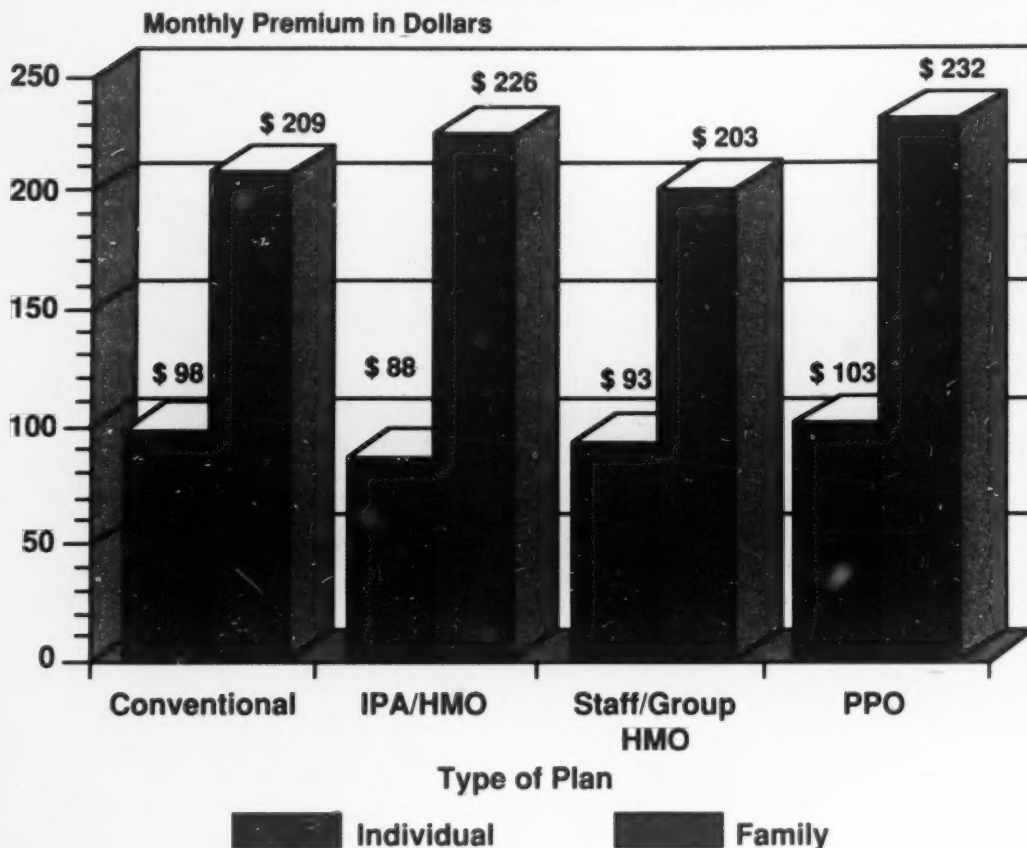
◆ Group and Individual Premiums

Group health insurance premiums paid to private insuring organizations have been increasing substantially for many years. Contributing factors to this growth in premiums are the extension of health insurance coverage to small groups not previously eligible and the need to fund larger benefit levels to meet health care cost increases.

In 1987, insurance companies earned \$70.3 billion in group premiums and \$10.0 billion in individual and family policy premiums. During this year, 51 percent of the group premiums were paid through arrangements where the insurance companies, for a fee, agreed to handle claims, benefits and administrative functions (ASO) or insure against large claims (MPP) for self-insured groups. (Table 3.4)

In a 1988 report on a survey of 1,665 public and private employers entitled *Employer-Sponsored Health Insurance in America: Preliminary Results from the 1988 Survey*, HIAA found that the average cost for individual coverage in a conventional plan was \$98, \$209 for a family. For staff-group HMO coverage it was \$93 for an individual and \$203 for a family. IPA/HMO coverage was \$88 for an individual and \$226 for a family. According to the survey preferred provider organizations (PPOs) are the most costly type of program, with a monthly premium of \$103 for an individual and \$232 for a family.

Monthly Premium Cost for Conventional, HMO and PPO Plans by Type of Plan, 1988



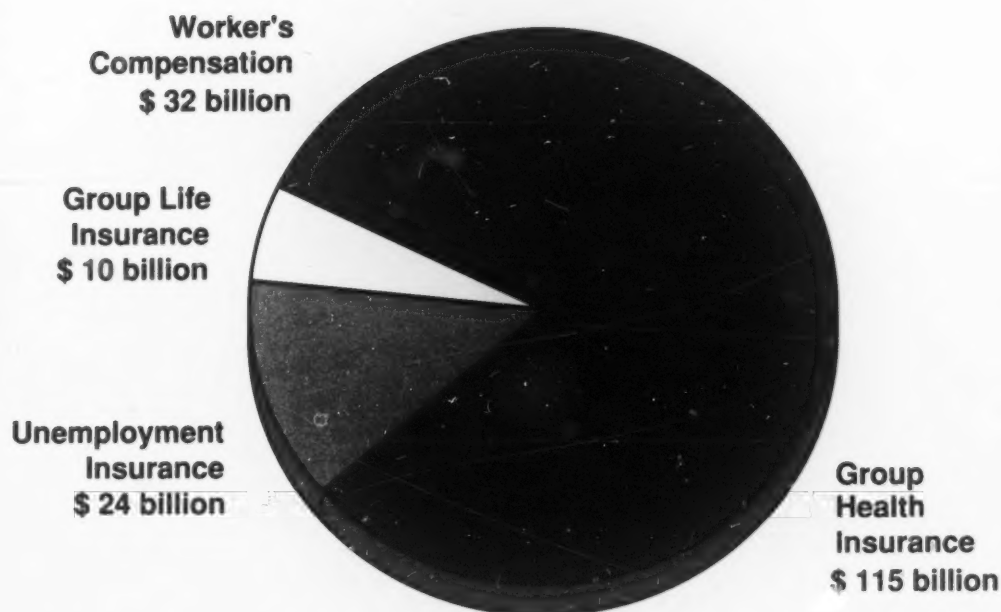
SOURCE: Health Insurance Association of America, *Employee-Sponsored Health Insurance in America: Preliminary Results from the 1988 Survey*.

According to this HIAA survey, 70 percent of the people in the country who had health insurance through their employers in 1987 were enrolled in HMOs, PPOs or managed fee-for-service plans (FFS).

◆ Insurance Premiums Paid by Employers

In the decade between 1970 and 1980, the amount of insurance premiums paid by American employers for their employee group insurance policies increased by 352 percent. During the mid-1980s premium increases were between 6 and 8 percent annually, but as we approach the end of this decade, premium increases are in double digits again. The chart below shows that in 1987 employers contributed \$115 billion for group health insurance to benefit their employees.

**Dollar Outlay by Employers for
Employee Insurance Coverage, 1987**
(From total compensation)



SOURCE: U.S. Department of Commerce, *Survey of Current Business*, Bureau of Economic Analysis.

Table 3.1

Health Insurance Premiums and Ratio to Disposable Personal Income (000,000 omitted)

Year	Insurance companies	Blue Cross-Blue Shield	Self-insured and HMO plans	Total premiums	Disposable personal income	Ratio
1950	\$ 1,266	\$ 687	NA	\$ 1,953	\$ 207,450	0.94
1955	2,743	1,523	NA	4,266	278,775	1.53
1960	4,671	2,814	NA	7,485	358,900	2.09
1965	7,352	4,777	NA	12,129	486,800	2.49
1970	11,546	8,439	NA	19,985	715,600	2.79
1975	20,795	17,611	NA	36,967	1,142,775	3.23
1978	32,713	21,547	\$10,970	63,067	1,551,225	4.07
1979	37,941	23,471	14,154	73,930	1,729,275	4.28
1980	43,666	26,334	17,340	84,742	1,917,900	4.42
1981	48,998	30,447	20,013	95,136	2,127,600	4.47
1982	58,341	34,338	22,884	109,472	2,261,425	4.84
1983	63,190	37,611	25,577	119,876	2,428,100	4.94
1984	70,440	39,954	28,564	127,635	2,668,600	4.78
1985	75,169	41,508	36,691	139,525	2,838,700	4.92
1986	75,486	43,523	40,600	143,389	3,019,600	4.75
1987	80,395	46,345	49,000	157,800	3,209,700	4.92

SOURCE: Health Insurance Association of America.

Table 3.2

Group Health Insurance Premiums of Insurance Companies in the United States (000,000 omitted)

Year	Total group	Hospital/Medical	Dental	Long-term care	Medicare supplement	Loss of income
1979	\$31,724	\$26,791	NA	NA	NA	\$4,933
1980	36,801	28,246	\$3,211	NA	\$ 67	5,277
1981	42,465	33,013	4,064	NA	148	5,240
1982	50,031	39,630	4,762	NA	140	5,499
1983	54,939	44,387	5,314	NA	139	5,099
1984	60,841	49,622	5,707	NA	506	5,006
1985	64,366	52,741	6,236	NA	553	4,836
1986	65,903	52,949	6,164	\$ 6	1,818	4,966
1987	70,309	56,833	6,356	20	1,792	5,308

SOURCE: Health Insurance Association of America.

Table 3.3

Individual Insurance Premiums of Insurance Companies in the United States (000,000 omitted)

Year	Total individual	Hospital/Medical	Long-term care	Loss of income
1978	\$ 5,774	\$3,784	NA	\$1,990
1979	6,217	4,121	NA	2,096
1980	6,865	4,909	NA	1,956
1981	6,533	4,699	NA	1,834
1982	8,310	5,777	NA	2,533
1983	8,251	6,258	NA	1,993
1984	9,599	7,225	NA	2,374
1985	10,803	7,886	NA	2,917
1986	9,583	6,611	\$ 87	2,885
1987	10,086	6,735	220	3,131

SOURCE: Health Insurance Association of America.

Table 3.4

Group Health Insurance Premiums of Insurance Companies in the United States by Type of Financing Arrangement (000,000 omitted)

Year	Total group premiums	Fully Insured		ASO		MPP	
		Hospital/Medical	Loss of income	Hospital/Medical	Loss of income	Hospital/Medical	Loss of income
1978	\$26,939	\$22,400†	\$4,539†	NA	NA	NA	NA
1979	31,724	26,791†	4,933†	NA	NA	NA	NA
1980	36,801	23,018	4,614	\$ 2,395	\$203	\$ 6,111	\$460
1981	42,465	22,368	4,059	3,995	324	10,863	856
1982	50,031	24,610	4,218	5,684	406	14,236	876
1983	54,939	27,497	3,767	6,110	462	16,233	870
1984	60,841	26,891	3,536	10,703	482	18,240	989
1985	64,366	27,648	3,454	13,117	558	18,765	824
1986	65,903	27,084	3,392	15,441	778	18,411	797
1987	70,309	30,720	3,706	16,965	933	17,317	668

SOURCE: Health Insurance Association of America.

†Breakout by financing arrangement not available.



Chapter 4

GOVERNMENT HEALTH CARE PROGRAMS

In 1987, \$207 billion of the National Health Expenditure (NHE) was spent for government health and medical programs at all levels to provide medical and health care services, fund research projects and construct medical facilities.

As the number of programs paid for by public monies increased, public expenditures increased by 9.7 percent in 1987. This was the largest annual increase since Medicare was introduced in 1966. Health expenditures per person increased from \$349 in 1970 to \$1,987 in 1987.

National Health Expenditures Aggregate
(selected calendar years 1970-1987)

	1970	1975	1980	1983	1984	1985	1986	1987
NHE	\$75.0	\$132.7	\$248.1	\$357.2	\$388.5	\$419.0	\$455.7	\$500.3
Private	47.2	76.4	142.9	209.7	228.8	244.0	266.8	293.0
Public	27.8	56.3	105.2	147.5	159.6	175.0	188.9	207.3
Federal	17.7	37.0	71.0	102.7	112.0	123.1	132.8	144.7
State/local	10.1	19.3	34.2	44.8	47.7	52.0	56.1	62.7

SOURCE: Health Care Financing Administration.

◆ FEDERAL PROGRAMS

Prior to 1967, federal health expenditures were less than half of total government expenditures for health care. By 1987, federal expenditures for health care had reached an amount more than double state and local expenditures.

The majority of federal health spending is for health services to six major groups: low-income individuals and those eligible for Medicaid, those over age 65 (Medicare), military personnel and their dependents, veterans, federal civilian employees and native Americans.

Medicare

Medicare, effective since July 1, 1966, is a federally administered program that provides hospital and medical insurance protection to those aged 65 and older, disabled persons under age 65 who receive cash benefits under Social Security or Railroad Retirement programs and people of all ages with chronic kidney disease. Aliens and some federal civil service employees and annuitants have been eligible to enroll by paying a monthly premium since 1973.

Many aged or disabled members who are covered by Medicare also are covered by Medicaid. Where this dual coverage exists, most state Medicaid programs pay the Medicare premiums, deductibles and copayments and for services not covered by Medicare.

Medicare consists of two parts: compulsory hospitalization insurance (HI) called Part A and voluntary supplementary medical insurance (SMI) called Part B, which supplements payment for physicians' services, medical services and supplies not covered under Part A. Part A is financed by contributions from employers, employees and participants; Part B is voluntary and is financed in part by monthly premiums paid by those who enroll and the federal government.

On January 1, 1989, Medicare's Part A deductible rose from \$540 to \$560. The monthly Part B premium went from \$24.80 to \$27.90. To help cover the cost of new catastrophic benefits, the elderly will pay a \$4 monthly premium. Under a recent ruling, Medicare will pay for at least 28 hours of skilled nursing and home health aide services per week and up to 8 hours a day.

Insurance companies, Blue Cross and Blue Shield plans and several other independent organizations serve as fiscal intermediaries for the government. More than 6,500 hospitals have an agreement to participate under the Medicare prospective payment system (PPS). Exceptions are psychiatric, children's, long-term care and rehabilitation hospitals, and medical facilities that have an approved waiver.

The cornerstone of the Medicare PPS system and the basis for payment are the diagnosis-related groups (DRG) developed by Yale University researchers in the 1970s as a mechanism for utilization review. DRGs are derived from taking all the possible diagnoses identified in the International Classification of Diseases (ICD-9-CM) system, classifying them into 23 major diagnostic categories (MDCs) based on organ systems, and further breaking them into 470 distinct groupings.

During the 20 years between 1968 and 1988, enrollment in the Medicare program has increased from 20 million to almost 33 million people. The combination of an increase in this country's population and longer life expectancies contributed to the total enrollment in 1988 of 14 million males and 19 million females. White enrollees numbered 28.1 million and 4.3 million were of other racial origins.

Nearly \$80 billion were paid by the federal government to Medicare enrollees in 1987. (Table 4.1)

Projections by the Health Care Financing Administration (HCFA) indicate that by the year 2050 there will be 69 million people over the age of 65 years who are eligible for Medicare. Fifteen million of these citizens will be age 85 or over.

Medicaid

This federal-state program of medical assistance under the Social Security Act became federal law in 1965 and provides medical assistance to certain low-income individuals and families.

Administered by each state according to designated federal requirements and guidelines, the program is financed from both state and federal funds. It provides medical assistance to persons who are eligible for such cash assistance programs as Aid to Families of Dependent Children and Supplemental Security Income. Medicaid benefits also may be available to other persons who have enough income for basic living expenses but cannot afford to pay for their medical care.

To qualify for federal matching funds, the law requires state programs to include inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing and home health services for individuals aged 21 and older. Services such as periodic screening, diagnosis and treatment and family planning for children under 21 and physicians' services also must be provided. Participation in the Medicaid program is optional and currently all states except Arizona participate.

As indicated in Table 4.2, the Medicaid program paid \$45.1 billion to 23 million recipients in 1987.

Utilization of Medicaid and Medicare Services

According to a recent report from HCFA, it is projected that 46 million Americans will receive services paid for by Medicare or Medicaid in 1988. One out of five (9 million) will use inpatient hospital services, 37 million will receive reimbursable physician services, 22 million will be paid for outpatient visits, and more than 800,000 will receive benefits for care in skilled nursing facilities. Medicaid will provide 15 million people with prescription drugs and a combination of Medicare and Medicaid benefits will provide services to 2 million recipients for home health care.

◆ OTHER GOVERNMENT SERVICES

Military Personnel and Dependents

Medical treatment at any Department of Defense (DOD) installation medical facility is available to all active and retired military personnel and their dependents. A program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is designed for military families unable to use government medical facilities because of distance, overcrowding or unavailability of appropriate medical treatment. It provides payment (after a deductible) for medical care. Retired military personnel and their dependents and dependents of deceased personnel are compensated by CHAMPUS if they are not eligible for Medicare. The CHAMPUS program spent \$2.4 billion out of the \$12.4 billion budgeted by the DOD for medical care in 1988.

Federal Civilian Employees

A variety of insurance programs (including HMOs) such as the Federal Employees Health Benefits Program are available to civilian employees who work for the federal government. Premiums are paid biweekly by the employing agency and the employee. In 1988, 4 million active and retired federal civilian employees and their dependents were enrolled in these programs.

In addition to federal payment of the employer contributions under these programs, the government also incurs administrative expenses for the operation of on-site health care facilities for federal civilian employees.

In fiscal 1988, civilian health programs cost the government nearly \$6.1 billion.

Veterans Medical Care

The government budgeted \$215.6 million for Veterans Administration (VA) medical research in 1988. In addition the VA operates 170 medical centers and 232 outpatient clinics for the care of individuals who served honorably in the armed forces. Patients with service-related ailments receive top priority.

Indian Health Services

More than \$1 billion in federal funds was appropriated in 1988 to provide medical care and health services for 2 million American Indians and Alaskan natives.

State and Local Programs

The public health programs of state health agencies (SHAs) and local health departments (LHDs) can be divided into four primary program areas: personal health, environmental health, health resources and laboratory services. In addition to these primary programs the agencies also perform general administrative and service functions. Not all SHAs perform the same services. In some states, designated expenditures for mental health care may be controlled by a separate mental health agency.

During fiscal year 1986 (the latest year for which data is available), 55 SHAs spent a total of \$7.5 billion for their public health programs (excluding Medicaid) which was distributed as follows: personal health, \$5.5 billion; environmental health, \$480 million; health resources, \$651 million; laboratory, \$238 million; and general administration, \$465 million. (Table 4.5)

The bulk of SHA expenditures for 1986 were for maternal and child health, communicable diseases, handicapped children, dental health, chronic disease, mental health, SHA-operated institutions, home health care and services to special population groups (i.e., immigrants and refugees).

There were 2,870 LHDs in 1986. U. S. territories and possessions (except Puerto Rico and American Samoa), three states and the District of Columbia do not have LHDs.

Table 4.1

Medicare Enrollments and Benefit Payments (000,000 omitted)

Calendar year	Hospital and/or medical insurance		Hospital insurance (Part A)		Supplementary medical insurance (Part B)	
	Number of enrolled persons*	Benefit payments	Number of enrolled persons*	Benefit payments	Number of enrolled persons*	Benefit payments
All enrollees						
1966 (July-Dec.)	19.1	\$ 1,019	19.1	\$ 891	17.7	\$ 128
1967	19.5	4,549	19.5	3,353	17.9	1,197
1968	19.8	5,697	19.8	4,179	18.8	1,518
1969	20.1	6,603	20.9	4,739	19.2	1,865
1970	20.5	7,099	20.4	5,124	19.6	1,975
1971	20.9	7,868	20.7	5,751	20.0	2,117
1972	21.3	8,643	21.1	6,318	20.4	2,325
1973	23.5	9,583	23.3	7,057	22.5	2,526
1974	24.2	12,418	23.9	9,099	23.2	3,318
1975	25.0	15,588	24.6	11,315	23.9	4,273
1976	25.7	18,420	25.3	13,340	24.6	5,080
1977	26.5	21,773	26.1	15,735	25.4	6,038
1978	27.2	24,919	26.8	17,667	26.1	7,252
1979	27.9	29,313	27.5	20,605	26.8	8,708
1980	28.5	35,686	28.1	25,051	27.4	10,635
1981	29.0	43,442	28.6	30,329	27.9	13,113
1982	29.5	51,086	29.1	35,631	28.4	15,455
1983	30.0	57,443	29.6	39,337	29.0	18,106
1984	30.5	62,870	30.0	43,209	29.4	19,661
1985	31.1	70,391	30.6	47,444	30.0	22,947
1986	31.7	74,187	31.2	49,018	30.6	25,169
1987	32.4	79,904	31.8	49,967	31.2	29,937
Enrollees age 65 and over						
1966 (July-Dec.)	19.1	\$ 1,019	19.1	\$ 891	17.7	\$ 128
1967	19.5	4,549	19.5	3,353	17.9	1,197
1968	19.8	5,697	19.8	4,179	18.8	1,518
1969	20.1	6,603	20.0	4,739	19.2	1,865
1970	20.5	7,099	20.4	5,124	19.6	1,975
1971	20.9	7,868	20.7	5,751	20.0	2,117
1972	21.3	8,643	21.1	6,318	20.4	2,325
1973	21.8	9,192	21.6	6,803	20.9	2,389
1974	22.3	11,223	22.0	8,295	21.4	2,928
1975	22.8	13,994	22.5	10,250	21.9	3,744
1976	23.3	16,339	22.9	11,959	22.4	4,380
1977	23.8	19,178	23.5	14,012	23.0	5,166
1978	24.4	21,796	24.0	15,644	23.5	6,152
1979	24.9	25,472	24.5	18,144	24.1	7,328
1980	25.5	31,031	25.1	22,096	24.7	8,935
1981	26.0	37,793	25.6	26,785	25.2	11,008
1982	26.5	44,393	26.1	31,413	25.7	12,980
1983	27.1	50,152	26.7	34,761	26.3	15,391
1984	27.6	55,374	27.1	38,321	26.8	17,053
1985	28.2	62,185	27.7	42,074	27.3	20,111
1986	28.8	57,127	28.2	40,456	27.9	16,671
1987	29.4	70,685	28.8	44,332	28.4	26,353

*As of July 1 (all areas).

NOTE: Some data have been revised. Detail may not add to totals due to rounding.

SOURCE: Department of Health and Human Services, Bureau of Data Management and Strategy, Health Care Financing Administration.

Table 4.2

Medicaid Recipients and Benefits Paid by Federal and State Governments* (000,000 omitted)

Fiscal year	Total		Age 65 and over		Dependent children†		All others	
	Annual recipients	Annual benefits paid	Annual recipients	Annual benefits paid	Annual recipients	Annual benefits paid	Annual recipients	Annual benefits paid
1972	17.6	\$ 6,300	3.3	\$ 1,925	11.0	\$ 2,101	2.3	\$ 2,274
1973	19.6	8,639	3.5	3,235	12.7	2,872	3.4	2,532
1974	21.5	9,983	3.7	3,691	13.9	3,398	3.9	2,893
1975	22.0	12,242	3.6	4,358	14.1	4,248	4.3	3,637
1976	22.8	14,091	3.6	4,910	14.7	4,719	4.5	4,462
1977	22.8	16,239	3.6	5,499	14.4	5,216	4.8	5,524
1978	22.0	17,992	3.4	6,308	14.0	5,421	4.6	6,264
1979	21.5	20,472	3.4	7,046	13.7	5,905	4.5	7,520
1980	21.6	23,311	3.4	8,739	14.2	6,354	4.4	8,217
1981	22.0	27,204	3.4	9,926	14.8	7,271	4.4	10,007
1982	21.6	29,399	3.2	10,739	14.9	7,566	4.3	11,094
1983	21.6	32,391	3.4	11,954	15.1	8,323	4.1	12,114
1984	21.6	33,895	3.2	12,819	15.3	8,400	4.1	12,675
1985	21.8	37,507	3.1	14,096	15.3	9,160	3.4	14,251
1986	22.5	41,027	3.1	15,100	15.7	10,013	3.7	15,915
1987	23.2	45,098	3.3	16,133	15.8	11,138	4.1	17,826

*Excludes territories and possessions.

†Includes adults in families with dependent children.

NOTE: Detail may not add to totals due to rounding. Excludes premium and per capita amounts and state expenditures not eligible for federal matching funds.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary, Medicaid, Statistics Branch.

Table 4.3

Medicare and Medicaid Benefits by State and Territory, 1987

States and Territories	Medicare		Medicaid	
	Benefits paid (000,000)	Number of persons enrolled (000)	Benefits paid (000,000)	Unduplicated count of recipients (000)
Alabama	\$ 1,211	553	\$ 366	289
Alaska	49	20	77	28
Arizona	1,087	445	*	*
Arkansas	781	377	410	212
California	9,915	3,090	4,816	3,689
Colorado	737	324	490*	189
Connecticut	1,109	451	749	217
Delaware	200	81	90	37
District of Columbia	300	79	358	97
Florida	5,682	2,135	1,178	640
Georgia	1,517	685	901	506
Hawaii	232	113	139	88
Idaho	225	123	89	40
Illinois	4,343	1,484	1,745	1,042
Indiana	1,563	725	924	301
Iowa	907	445	422	232
Kansas	830	352	282*	144
Kentucky	944	510	606	411
Louisiana	1,251	504	824	484
Maine	354	175	303	123
Maryland	1,388	506	765	312
Massachusetts	2,281	844	1,844*	541
Michigan	3,531	1,171	1,823	1,125
Minnesota	1,264	565	1,097*	337
Mississippi	755	353	363	342
Missouri	2,044	754	619	369
Montana	196	110	122	58
Nebraska	439	232	215	107
Nevada	300	114	86	34
New Hampshire	255	130	142	33
New Jersey	2,639	1,056	1,565*	661
New Mexico	333	162	183	97
New York	6,510	2,469	8,841	2,308
North Carolina	1,440	821	825	386
North Dakota	224	96	165	42
Ohio	3,643	1,467	2,377	1,132
Oklahoma	846	432	502	250
Oregon	850	394	254	168
Pennsylvania	5,485	1,879	2,077	1,102
Puerto Rico	224	407	180*	1,683
Rhode Island	421	154	296	102
South Carolina	796	406	422	267
South Dakota	201	107	116	40

Continued

Tennessee	1,353	654	811	443
Texas	4,053	1,689	1,767	986
Utah	227	145	152	82
Vermont	136	71	104	50
Virginia	1,222	670	662	318
Virgin Islands	5	7	4	14
Washington	1,266	568	759	392
West Virginia	684	297	244	215
Wisconsin	1,507	685	1,004	411
Wyoming	92	47	45*	27
Residence Unknown	32	20	.	.
Guam	3	3	.	.
Other & Foreign	22	257	.	.
U.S. Total	\$79,904	32,411	\$45,098	23,183

NOTE: Detail may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration.

*Indicates state data are estimated or data are not available.

Table 4.4

Hospital and Medical Expenditures under Worker's Compensation (000,000 omitted)

Year	State and local	Federal	Total
1965	\$ 787	\$ 12	\$ 799
1966	897	13	910
1967	996	15	1,012
1968	1,130	17	1,147
1969	1,244	19	1,263
1970	1,384	25	1,409
1971	1,414	27	1,441
1972	1,545	30	1,575
1973	1,848	35	1,884
1974	2,133	43	2,176
1975	2,371	61	2,436
1976	2,685	73	2,758
1977	3,112	79	3,191
1978	3,585	97	3,682
1979	4,424	117	4,541
1980	5,012	140	5,151
1981	5,536	159	5,695
1982	4,600	200	4,800
1983	5,100	300	5,400
1984	5,800	300	6,100
1985	6,700	300	7,000
1986	7,500	300	7,800
1987	8,600	300	8,900

NOTE: For 1970 and succeeding years data include federal "black lung" benefits. Detail may not add to totals due to rounding.

SOURCE: Health Care Financing Administration, Health Care Financing Notes, September 1988.

Table 4.5

State Health Agency Public Health Expenditure, by Program Area, Fiscal Year 1986 (000,000 omitted)

States and Territories (1)	Total SHA expenditures (2)	Personal health (3)	Environmental health (4)	Health resources (5)	Laboratory (6)	General administration (7)	Funds to LMDS not allocated to program areas (8)
Total	\$7,463,804	\$5,519,599	\$479,829	\$650,894	\$237,898	\$465,059	\$110,525
Alabama	79,613	54,115	1,885	3,925	5,209	7,595	6,884
Alaska	32,245	20,585	94	8,377	2,398	790	8
Arizona	135,039	102,783	15,088	5,985	2,488	8,696	—
Arkansas	61,933	44,201	6,953	2,031	1,995	6,753	—
California	692,817	383,609	37,081	191,111	28,395	52,621	—
Colorado	78,673	51,539	11,550	3,557	2,671	5,175	4,181
Connecticut	59,086	36,431	2,578	8,418	6,111	3,977	1,371
Delaware	40,405	35,466	2,338	683	799	1,119	—
Dist. of Columbia	160,262	141,934	—	1,459	1,704	15,165	—
Florida	297,042	191,892	38,098	35,485	11,771	11,056	8,741
Georgia	164,641	113,274	923	4,534	4,355	1,511	40,043
Hawaii	183,138	155,025	7,283	15,667	1,669	3,495	—
Idaho	22,060	16,925	82	1,975	2,164	914	—
Illinois	147,624	97,840	7,977	14,980	4,051	15,293	7,482
Indiana	98,984	75,920	8,845	3,949	2,064	7,406	—
Iowa	43,811	36,381	1,206	5,342	—	883	—
Kansas	41,092	22,372	8,617	4,592	2,287	3,225	—
Kentucky	108,009	62,391	4,804	6,938	3,111	19,208	11,558
Louisiana	120,065	98,928	11,330	4,062	4,615	1,131	—
Maine	22,503	17,463	1,482	1,807	1,565	187	—
Maryland	651,121	558,344	38,610	13,354	9,546	31,268	—
Massachusetts	241,393	222,051	8,418	4,666	537	5,721	—
Michigan	271,128	218,132	16,985	12,150	10,602	13,259	—
Minnesota	74,124	46,138	5,780	12,333	3,849	6,024	—
Mississippi	98,731	86,470	3,500	3,355	1,041	4,365	—
Missouri	82,032	69,467	3,934	4,486	2,117	2,028	—
Montana	.	.	.	.	.	.	—
Nebraska	24,930	16,053	1,490	5,588	937	862	—
Nevada	17,616	12,813	1,088	1,395	1,008	330	983
New Hampshire	21,881	13,783	3,161	2,953	985	1,001	—
New Jersey	146,100	88,051	8,584	33,061	7,065	9,339	—
New Mexico	155,594	128,067	10,621	4,765	3,048	9,093	—
New York	592,767	406,914	13,823	92,205	44,168	35,656	—
North Carolina	160,381	138,994	8,145	2,299	7,114	3,829	—
North Dakota	16,154	8,557	3,191	1,514	1,293	1,043	556

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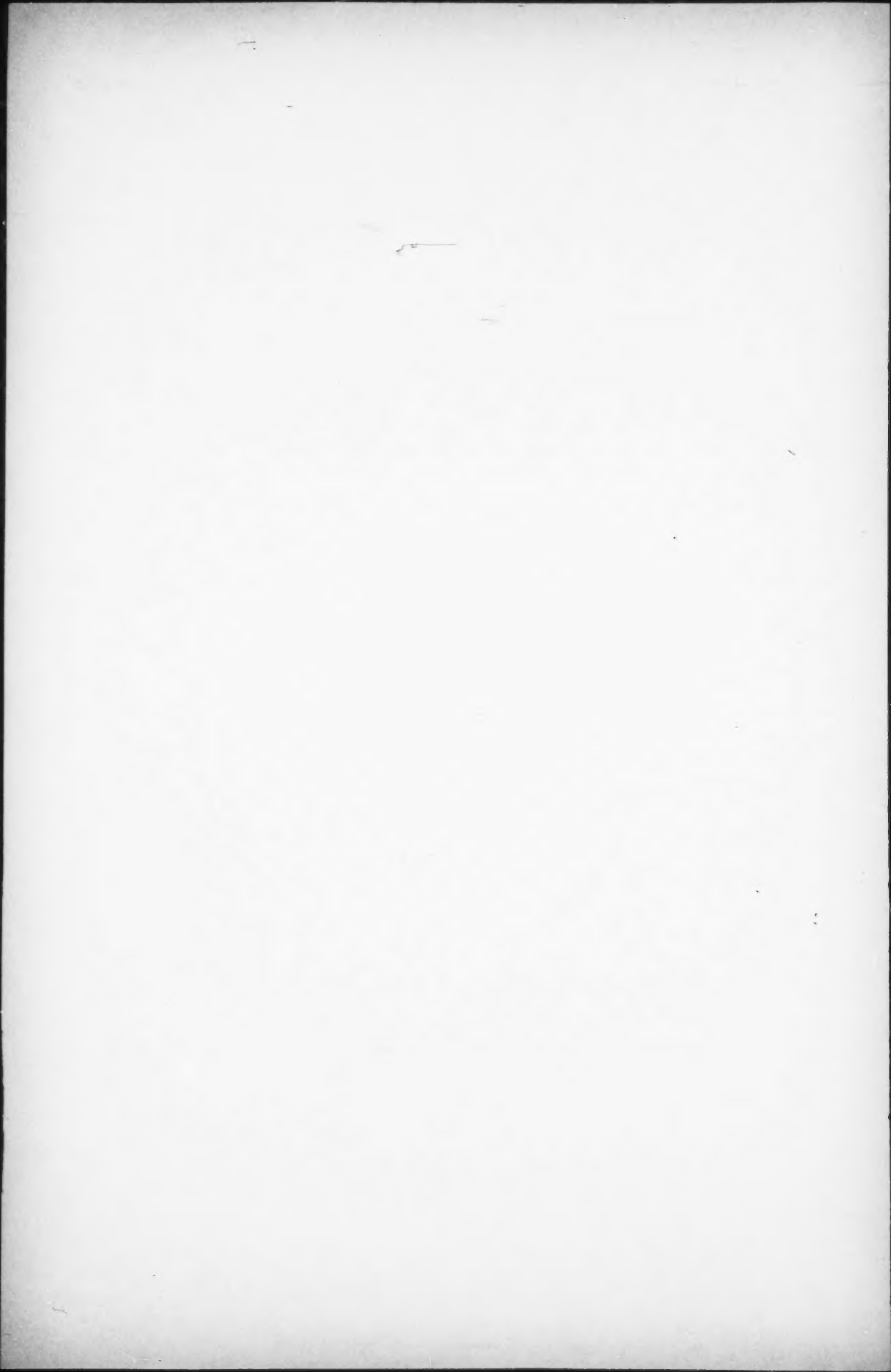
Ohio	157,634	126,678	3,802	10,382	3,982	10,034	2,756
Oklahoma	90,148	62,774	16,347	4,370	1,379	5,279	—
Oregon	38,446	24,896	2,367	4,664	2,720	2,593	1,207
Pennsylvania	240,060	202,397	6,510	22,467	3,157	5,529	—
Rhode Island	28,678	13,947	3,842	5,428	3,990	1,471	—
South Carolina	170,568	119,394	28,163	5,729	4,809	12,474	—
South Dakota	.	.	.	.	.	.	—
Tennessee	156,103	110,913	23,513	7,820	5,582	8,275	—
Texas	296,888	225,670	20,124	22,368	5,758	15,380	7,588
Utah	65,583	28,265	28,317	2,999	3,135	2,867	—
Vermont	18,881	14,211	1,187	1,798	1,361	324	—
Virginia	187,888	126,017	23,437	8,906	1,875	21,824	5,828
Washington	61,111	42,209	9,691	3,958	3,490	1,765	—
West Virginia	147,185	127,726	1,875	4,972	2,512	4,021	6,078
Wisconsin	75,526	37,740	3,946	10,565	1,380	16,624	5,271
Wyoming	.	.	.	.	.	.	—
American Samoa	.	.	.	.	—	.	—
Guam	.	.	.	.	.	.	—
Puerto Rico	454,603	389,458	3,481	7,810	1,275	52,580	—
Virgin Islands	66,089	47,797	658	1,530	5,137	10,966	—

*Data have been estimated for the areas in American Samoa, Guam, Montana, South Dakota and Wyoming, which did not report to the Public Health Foundation for fiscal year 1986. Estimated data have been included in the underlined totals.

NOTE: The data in this table relate only to expenditures of official state health agencies. The public health expenditures of other agencies such as separate mental health authorities, environmental agencies and hospital authorities are not reflected in the Public Health Foundation's database.

Standard symbols: — = zero or no data; # = less than 0.5 percent or less than \$500; E = estimated by the respondent; U = data reported as unobtainable by the respondent; C = data for this item was combined with reporting of another item.

SOURCE: Public Health Foundation, 1220 L Street, N.W., Suite 350, Washington, D.C. 20005.



Chapter 5

MEDICAL CARE COSTS

Each year Americans spend more for health care. These higher costs in part reflect new technologies that help to reduce pain and suffering and extend life. Americans are also consuming some kinds of services in higher volume. To some extent this increase in utilization reflects growth in the needs of an aging population and growth in the total population, but much of it is simply greater consumption across the board. The fact that medical prices consistently escalate more rapidly than consumer prices also contributes to the cost trends.

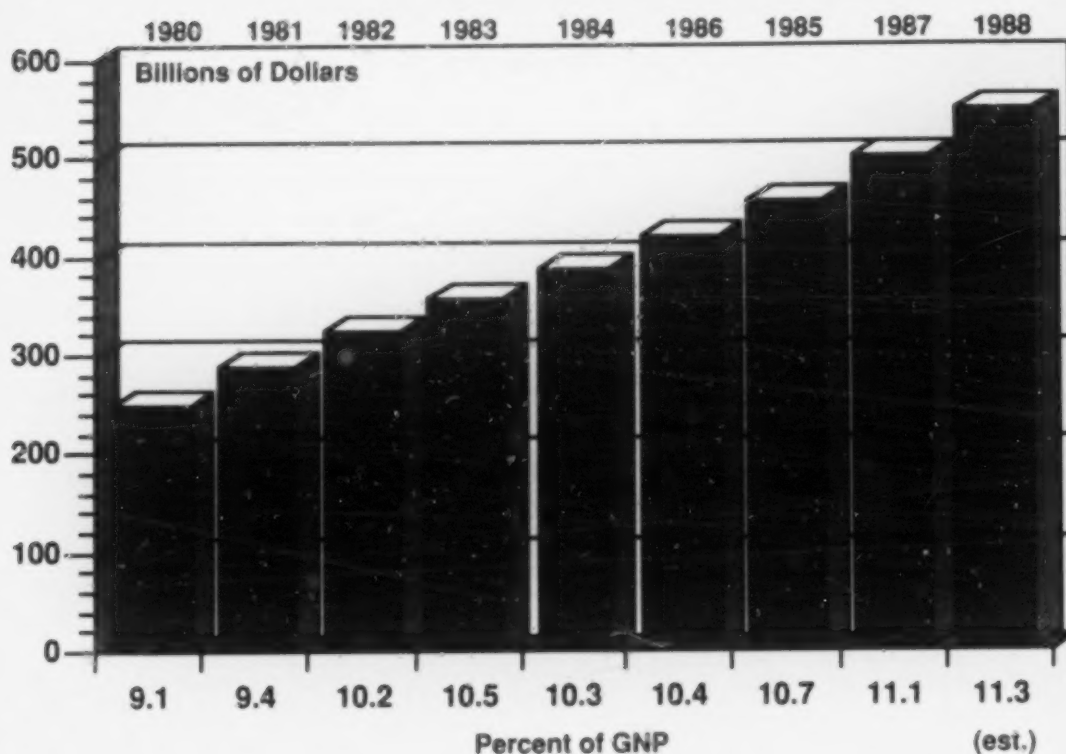
There is much evidence that resources are not efficiently allocated in our nation's health care sector. Thus some of the cost increases can be attributed to inefficiency and to the consumption of marginally effective services. Unless the system becomes more efficient and the historic rate of increase in health care costs can be constrained, the position of American business in international markets will continue to erode and the number of Americans who cannot afford adequate health insurance increase.

◆ National Health Expenditure

Total health care spending, represented by the National Health Expenditure (NHE), includes both private and public expenditures for personal health care, medical research, the construction of medical facilities, administrative and insurance costs and government-sponsored public health programs. The NHE covers spending for health care over the 12-month calendar year.

National health spending reached \$500.3 billion in 1987, showing a 9.8 percent increase over 1986, compared with 8.7 percent the previous year. Public spending, which financed 41.5 percent of all health care costs in 1986, decreased slightly while private spending remained about the same at 58.6 percent of the NHE in 1987.

National Health Expenditure and Percent of Gross National Product



SOURCE: Health Care Financing Administration. *Health Care Financing Administration Review*, various issues.

In 1977, the NHE constituted 8.5 percent of the Gross National Product and has steadily increased over the years, reaching 11.1 percent in 1987. (Table 5.2)

Hospital care, totaling \$194.2 billion in 1987, continued to represent the largest share of spending for health care. The cost of physicians' services was the next highest at \$102.7 billion. (Table 5.3)

HCEA projects the nation's health expenditure will reach \$647.3 billion by 1990.

◆ Personal Health Care Expenditure

The Personal Health Care Expenditure (PHCE) figure, 88.5 percent of the National Health Expenditure, represents private and public spending for direct health and medical services to individuals.

Factors Affecting Growth of Personal Health Care Expenditures
(12-month period ending December)

	1981	1982	1983	1984	1985	1986	1987
All Factors	100%	100%	100%	100%	100%	100%	100%
Prices	67	69	67	73	61	52	52
Population	7	9	10	12	11	11	9
Intensity	26	22	23	15	28	37	39

Spending for personal health care in the nation amounted to \$443 billion in 1987 (Table 5.6). Included in this figure are expenditures for hospital care, professional services, drugs and medical sundries and nursing home care. Not included are expenditures for medical research, construction of medical facilities, public health activities such as disease prevention and control and the net cost of health insurance. These items are included in the NHE figure.

Table 5.7 shows the per capita amounts of personal expenditures. Per capita expenditure was \$1,758 in 1987, 9 percent more than the 1986 figure of \$1,610. By 1990 per capita expenditure is expected to reach \$2,511.

According to HCFA, U.S. nursing home expenses in 1987 came to \$40.6 billion. Medicare contributed only \$600 million to this total. Medicaid paid nearly half (\$17.8 billion) of these expenses, making it a defacto long-term care financing program. The remaining cost of financing long-term care fell almost exclusively on the patients and their families (\$20 billion). Private long-term care insurance, still in its infancy, paid only \$400 million.

The largest portion (72 percent) of the personal health care dollar is financed by third-party sources. (Table 5.6) Private health insurance, philanthropy, industry and the government paid \$319.6 billion of all expenditures for personal health care in 1987.

Personal health care figures include expenditures for consumers, whether insured or not. Included are expenses for nonprescribed drugs and medicines, household supplies and other items not covered by insurance.

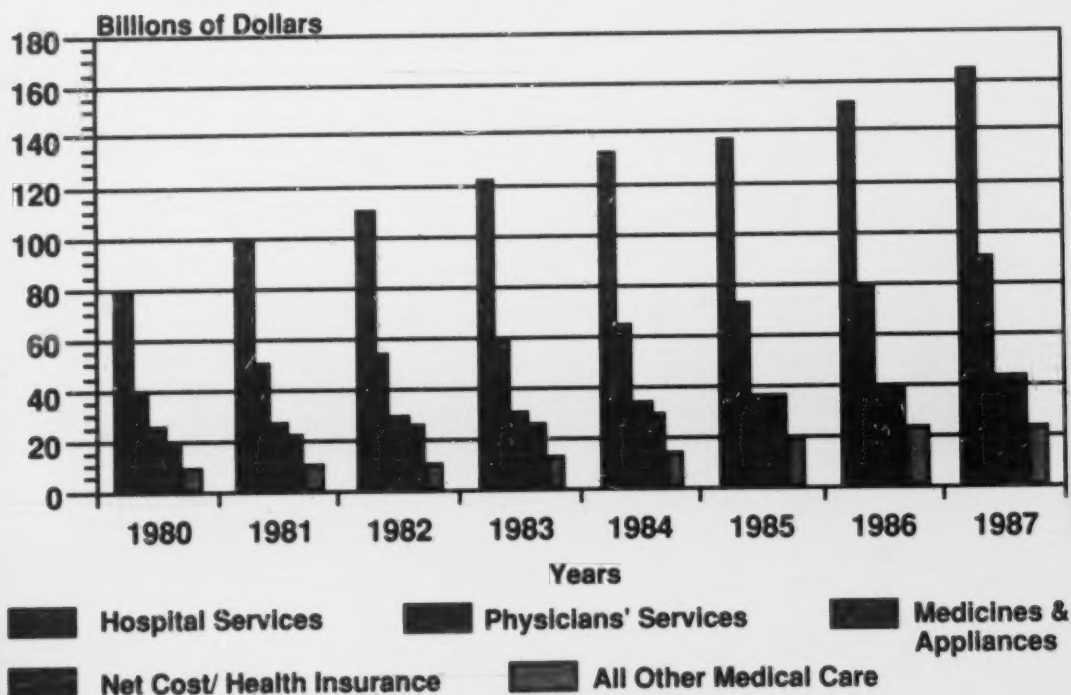
◆ Personal Consumption Expenditure

Personal Consumption Expenditures (PCE) for medical care represent private payments. Monies from three government programs (Medicare, Worker's Compensation and Temporary Disability Insurance) are treated as transfer payments and are included. The PCE is computed as an annual average. Basic categories of expenditures constitute the PCE for medical care and the PHCE portion of the NHE figure; different accounting practices are used for each.

PCEs for medical care were \$400.8 billion for 1987 (Table 5.8), three times the amount spent 10 years earlier. The 1987 amount represents 13.3 percent of the total spent by Americans on all personal needs, compared with 10.1 percent a decade earlier. As a proportion of the public's disposable income, these expenditures were 12.5 percent in 1987, up from an 11.8 percent increase in 1986. (Table 5.9)

PCEs for nongovernmental hospital care (including expenses of nonprofit hospitals, sanitariums and nursing homes, and payments for patients to proprietary hospitals, sanitariums and nursing homes) were \$167.4 billion in 1987 (Table 5.10), more than three times the amount in 1977. Payments for physician's services were \$93.9 billion, three times the amount spent a decade ago.

Personal Consumption Expenditures



SOURCE: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, various issues.

◆ Consumer Price Index

The Consumer Price Index (CPI) measures the average change in prices of all types of consumer goods and services purchased by urban wage earners and clerical workers. The index measures only the effect of price change on the cost of living. It does not measure changes in the total amount families spend.

According to the 1988 CPI, medical costs increased by 6.5 percent over 1987, compared with the 4.1 percent increase for all items. (Table 5.12)

Individual components of medical care have differed in their rate of increase, but hospital room rates have risen most rapidly.

Percent Change in Price by Regions
of the United States, 1987-1988

	Total medical care	Medical care commodities	Total medical care services	Professional services
Northeast	6.4	6.4	6.4	7.0
North Central	6.5	6.9	6.4	7.3
South	6.1	6.8	5.9	6.4
West	6.9	7.1	6.9	6.6

SOURCE: U.S. Bureau of Labor Statistics.

◆ Hospital Charges

Community Hospital Statistics

In 1987, the average cost for treating a patient in a community hospital was \$538.96 per inpatient day, almost an 8 percent increase over 1986. On a state-by-state basis, the average charge per day in 1987 varied considerably from a low of \$317.59 in South Dakota to a high of \$892.02 in Alaska.

In 1987, the average length of time a patient remained in a community hospital was 7.2 days, up from 7.1 days one year earlier. The increase in length of stay was accompanied by an increase in the average cost of a stay in a community hospital in 1987 to \$3,850.16, a 9 percent increase over 1986.

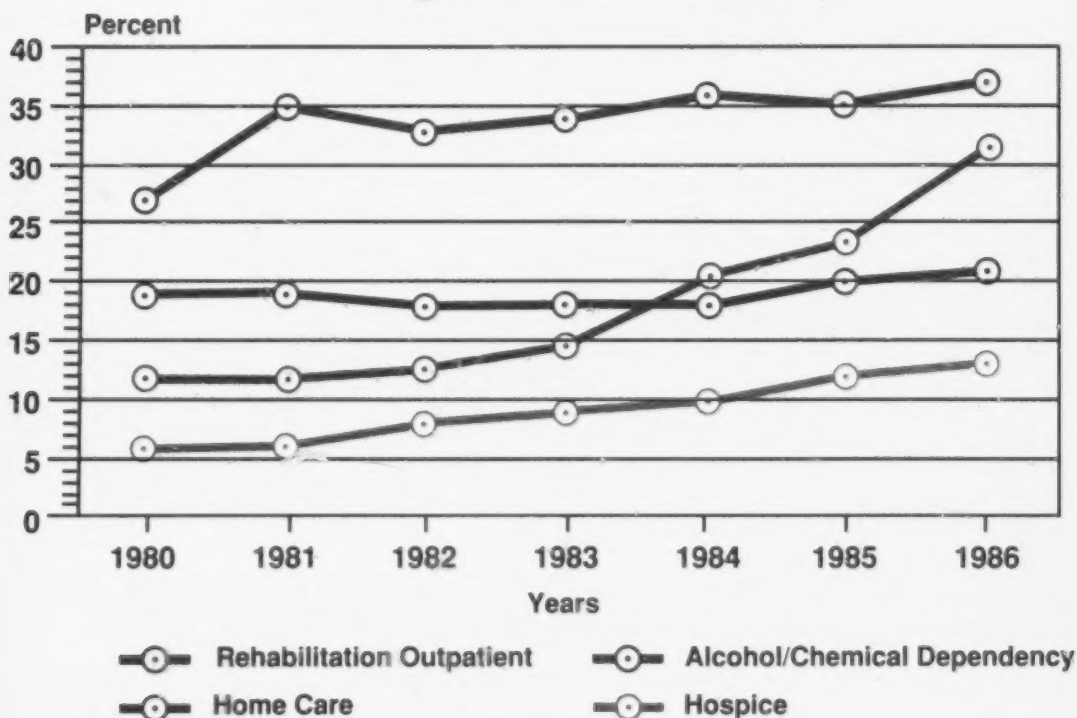
The average length of stay varied by area, from a low of 5.3 days in Oregon to a high of 10.1 in North Dakota. Differences reflect differences in medical practice patterns, the incidence of various diseases, age distribution of the population, income levels and postponement of nonemergency admissions.

The American Hospital Association (AHA) reports that labor costs reached \$81 billion, representing 53 percent of community hospital expenditures in 1987.

Operating costs of community hospitals were \$153 billion in 1987, which is an 8.5 percent increase over the \$141 billion spent in 1986.

During the past decade, hospitals have broadened the range of alternative services that they offer. These changes reflect advances in technology, a greater emphasis on nonacute care in new payment systems and medical care, which allows a greater choice for the patient.

Hospital Outpatient Service (Percentage of community hospitals offering services since 1980)



SOURCE: American Hospital Association, *Hospital Statistics*, various issues.

Psychiatric Hospital Statistics

The nation's 684 nonfederal mental hospitals were 86 percent occupied in 1987, with an increase in admissions of 8.7 percent between 1977 and 1987. There was a sharp decline in the average length of stay from 131 days in 1977 to 81 days in 1987. This led to a 32 percent reduction in inpatient days in psychiatric hospitals in the 10-year period. According to AHA's 1988 *Hospital Statistics*, it cost in excess of \$10 billion to operate facilities devoted to mental health care in the United States in 1987.

Semiprivate Room Charges

A continuing survey conducted by HIAA shows that as of January 1988, the national average room and board cost to the patient for a semiprivate room was \$254.87 per day, a 6.7 percent increase over January 1987. (Table 5.16) Survey results are based on responses from 1,414 nongovernmental short-term general hospitals nationwide. The highest regional daily average rate of \$308 was in the West. The lowest rate was in the South, at \$207 per day.

◆ Professional Fees

Surgical Charges

Surgical charges vary considerably by geographic region and by metropolitan and nonmetropolitan areas. Table 5.17, containing data from a 1988 survey by *Medical Economics* magazine, shows the fee for a number of common surgical procedures and emergency medical procedures across the United States.

The Division of Health Care Statistics of the National Center for Health Statistics listed the 10 most frequently performed surgical procedures in 1986 as follows:

Procedure	Numbers in 1,000
Biopsy	1,412
Cesarean section	906
Hysterectomy	644
Repair OB (Birth) laceration	612
Operations on spinal chord and spinal canal	571
Excision of skin lesions	565
Arthroplasty of joints	537
Cholecystectomy	502
Oophorectomy and salpingo-oophorectomy	502
Dilation and curettage of uterus	472

Data from the 1988 HIAA Prevailing Healthcare Charges System show charges by geographic areas of the United States. Selected surgical procedures are shown below:

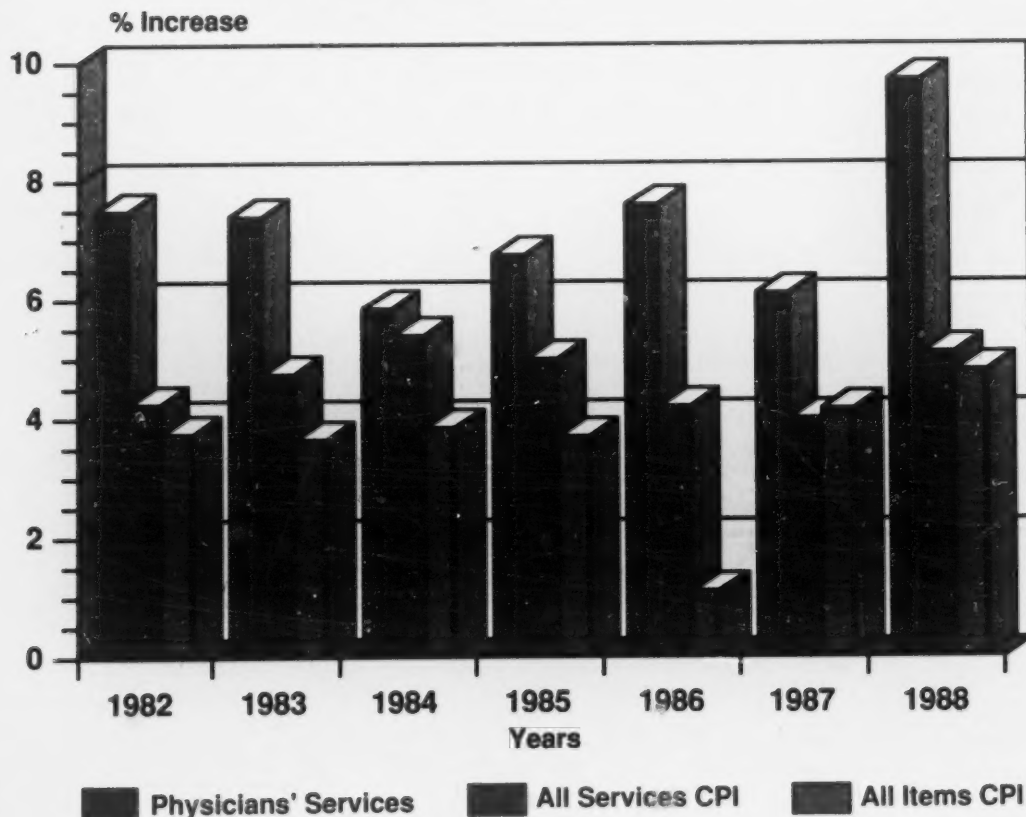
Procedure	New York City	Philadelphia	Atlanta	Chicago	Dallas	Los Angeles
Excision of breast lesion (lumpectomy)	\$1,100	\$ 513	\$ 494	\$ 539	\$ 526	\$ 664
Coronary bypass (triple)	8,081	5,649	3,950	5,361	4,256	5,343
Appendectomy	1,747	864	829	989	855	1,073
Cholecystectomy	2,396	1,352	1,136	1,445	1,227	1,672
Vasectomy	574	406	343	403	321	432

NOTE: Health Insurance Association of America's Surgical Prevailing Healthcare Charges System is copyrighted and is available by subscription only to certain types of organizations.

Physician Fees

Tables 5.19 and 5.20 show that physician fees vary considerably by type of practice or specialty, type of visit and region of the United States. In 1988, the median charges for an initial office visit and an office revisit were highest for specialists and for physicians practicing in the western states. According to a continuing survey done by *Medical Economics* magazine, physicians' fees have historically risen at a higher rate than the CPI. All services of the CPI showed a 5.2 percent increase while physicians' fees rose almost 10 percent in 1988.

Physicians' Services and the CPI (Fees rise faster than CPI)



SOURCE: *Medical Economics*, Oct. 3, 1988.

◆ Cost of Having a Baby

A good maternity package is an important feature of the group medical expense plans provided by employers. Maternity coverage is often mandated by state law, and more than 95 percent of employees with maternity coverage under employer-sponsored group policies underwritten by commercial insurance companies have benefits equal to those for any other medical condition.

A national survey was conducted by HIAA in 1986 to determine the costs of usual and cesarean births across the United States. The average cost of a usual birth in a hospital delivery room was found to be \$2,560, a 25 percent increase over the delivery cost of \$2,047 reported in a similar survey done by the HIAA in 1982. The total costs varied in the states and regions across the country, with the nonmetropolitan Midwest reporting the lowest cost of \$2,250 and the metropolitan West reporting the highest charge of \$3,090. (Table 5.20)

Most births in this country occur by normal delivery. However, the number of cesarean deliveries increased from 4.5 percent of all births in 1965 to 21.1 percent in 1984. Cesarean births have remained at 3.5 to 4.0 percent of the total surgical procedures ever since. The average cost of an uncomplicated cesarean in the United States was \$4,270 in 1986.

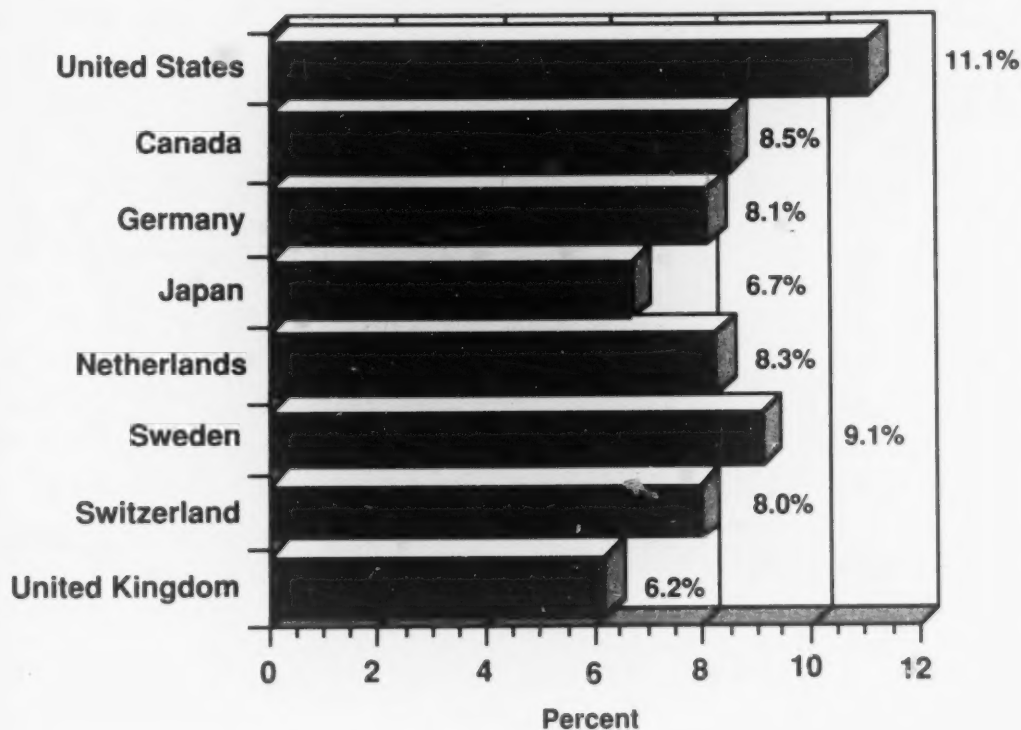
◆ Medical Costs Resulting from Accidents

The economic losses that result from various types of accidents are shown in Table 5.22. Medical expense costs incurred through accidents totaled \$133.2 billion in 1987.

◆ International Health Care Expenditure

According to the Organization for Economic Cooperation and Development (OECD), the United States spends more on health care than any other country relative to its economy. Gross domestic product differs from GNP in that it does not include net foreign investment income.

**Health Expenditures as Percent
of Gross Domestic Product, 1986**
(Selected countries)



SOURCE: *Health Affairs, International Health Care Spending and Utilization Trends*, Fall 1988.

Table 5.1

National Health Expenditures by Type of Expenditure and Source of Funds, 1987 (000,000,000 omitted)

Type of expenditure	Total	Private	Public
Personal health care	\$442.6	\$267.3	\$175.2
Program administration and net cost of insurance	25.9	19.4	6.6
Government public health activities	14.7	—	14.7
Research	8.8	0.6	8.2
Construction	8.3	5.7	2.6
Total	\$500.3	\$293.0	\$207.3

NOTE: Detail may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, Winter 1987.

Table 5.2

Comparison of Growth Rates of Gross National Product and National Health Expenditures

Calendar year	Gross National Product		National Health Expenditures		NHE as percent of GNP
	Amount (000,000,000)	Annual rate of growth	Amount (000,000,000)	Annual rate of growth	
1950	\$ 288.3	10.7%	\$ 12.7	12.2%	4.4%
1955	405.9	9.0	17.7	7.0	4.4
1960	515.3	3.9	26.9	8.7	5.2
1965	705.1	8.5	41.9	9.2	5.9
1970	1,015.5	5.3	75.0	14.3	7.4
1971	1,102.7	8.6	83.5	11.3	7.6
1972	1,212.8	10.0	94.0	12.6	7.8
1973	1,359.3	12.1	103.4	10.0	7.6
1974	1,472.8	8.3	116.1	12.3	7.9
1975	1,598.4	8.5	132.7	14.3	8.3
1976	1,782.8	11.5	150.8	13.6	8.5
1977	1,990.5	11.7	169.9	12.7	8.5
1978	2,249.7	13.0	189.7	11.7	8.4
1979	2,508.2	11.5	214.7	13.2	8.6
1980	2,732.0	8.9	248.1	15.6	9.1
1981	3,052.6	11.7	287.0	15.7	9.4
1982	3,166.0	3.7	323.6	12.8	10.2
1983	3,405.7	7.6	357.2	10.4	10.5
1984	3,772.2	10.7	388.5	8.8	10.3
1985	4,014.9	6.4	419.0	7.9	10.4
1986	4,240.3	5.6	455.7	8.7	10.7
1987	4,526.7	6.7	500.3	9.8	11.1

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, Winter 1988.

Table 5.3

National Health Expenditure by Type of Expenditure
(000,000,000 omitted)

Type of expenditure	1970	1975	1980	1985	1986	1987
Total	\$75.0	\$132.7	\$248.1	\$422.6	\$455.7	\$500.3
Health services and supplies	69.6	124.3	236.2	407.2	439.3	483.2
Personal health care expenses	65.4	117.1	219.7	371.3	401.6	442.6
Hospital care	28.0	52.4	101.6	167.2	178.4	194.7
Physicians' services	14.3	24.9	46.8	82.8	91.6	102.7
Dentists' services	4.7	8.2	15.4	27.1	29.6	32.8
Other professional services	1.6	2.6	5.7	12.4	14.1	16.2
Drugs and medical sundries	8.0	11.9	18.8	28.7	31.3	34.0
Eyeglasses and appliances	1.9	3.2	5.1	7.5	8.7	9.5
Nursing home care	4.7	10.1	20.4	35.0	37.4	40.6
Other health services	2.1	3.8	5.9	10.8	10.7	12.0
Program administration and net cost of insurance	2.8	4.0	9.2	23.6	23.9	25.9
Government public health activities	1.4	3.2	7.3	12.3	13.8	14.7
Research and medical facilities construction	5.4	8.4	11.9	15.4	16.4	17.1
Research	2.0	3.3	5.4	7.4	8.3	8.8
Construction	3.4	5.1	6.5	8.1	8.0	8.3

NOTE: Detail may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, Winter 1988.

Table 5.4

National Health Care Expenditures 1986-1987 by Type of Expenditure and Source of Funds (000,000,000 omitted)

Year and type of expenditure	Total	Private					Government		
		All private funds	Consumer			Other	Total	Federal	State and local
			Total	Direct	Private insurance				
1986									
National health expenditures	\$455.7	\$266.8	\$255.1	\$112.6	\$142.4	\$11.7	\$188.9	\$132.8	\$56.1
Health services and supplies	439.3	260.5	255.1	112.6	142.4	5.5	178.8	125.0	53.7
Personal health care	401.6	242.1	237.3	112.6	124.6	4.8	159.6	120.3	39.2
Hospital care	178.4	83.1	81.1	16.7	64.4	2.0	95.4	75.1	20.2
Physicians' services	91.6	63.9	63.9	23.7	40.2	0.1	27.6	22.4	5.3
Dentists' services	29.6	28.9	28.9	18.2	10.8	—	0.6	0.3	0.3
Other professional services	14.1	9.5	9.4	5.7	3.7	0.1	4.6	3.2	1.4
Drugs and medical sundries	31.3	27.9	27.9	23.7	4.2	—	3.4	1.7	1.7
Eyeglasses and appliances	8.7	6.9	6.9	5.9	1.0	—	1.7	1.6	0.2
Nursing home care	37.4	19.4	19.1	18.8	0.3	0.3	18.0	10.2	7.8
Other personal health care	10.7	2.4	—	—	—	2.4	8.3	5.9	2.4
Program administration and net cost of private health insurance	23.9	18.5	17.8	—	17.8	0.6	5.5	3.3	2.2
Government public health activities	13.8	—	—	—	—	—	13.8	1.4	12.3
Research and construction	16.4	6.2	—	—	—	6.2	10.1	7.8	2.4
Research	8.3	0.7	—	—	—	0.7	7.6	6.8	0.8
Construction	8.0	5.6	—	—	—	5.6	2.5	0.9	1.6
1987									
National health expenditures	\$500.3	\$293.0	\$280.8	\$123.0	\$157.8	\$12.2	\$207.3	\$144.7	\$62.7
Health services and supplies	483.2	286.7	280.8	123.0	157.8	5.9	196.5	136.3	60.2
Personal health care	442.6	267.3	262.1	123.0	139.1	5.3	175.3	131.2	44.1
Hospital care	194.7	92.6	90.4	18.5	71.9	2.2	102.2	80.0	22.2
Physicians' services	102.7	70.9	70.9	26.3	44.6	0.1	31.8	25.7	6.1
Dentists' services	32.8	32.2	32.2	20.0	12.1	—	0.7	0.3	0.3
Other professional services	16.2	10.8	10.7	6.4	4.3	0.1	5.4	3.6	1.8
Drugs and medical sundries	34.0	30.2	30.2	25.5	4.7	—	3.9	1.9	2.0
Eyeglasses and appliances	9.5	7.3	7.3	6.3	1.1	—	2.1	1.9	0.2
Nursing home care	40.6	20.6	20.4	20.0	0.4	0.3	19.9	11.1	8.9
Other personal health care	12.0	2.6	—	—	—	2.6	9.4	6.7	2.7
Program administration and net cost of private health insurance	25.9	19.4	18.7	—	18.7	0.7	6.6	3.5	3.1
Government public health activities	14.7	—	—	—	—	—	14.7	1.6	13.1
Research and construction	17.1	6.3	—	—	—	6.3	10.8	8.4	2.4
Research	8.8	0.6	—	—	—	0.6	8.2	7.4	0.8
Construction	8.3	5.7	—	—	—	5.7	2.6	1.0	1.6

SOURCE: Health Care Financing Administration, Office of the Actuary, Division of National Cost Estimates.

Table 5.5

**Personal Health Care Expenditures Aggregate, Per Capita,
and Percent Distribution, by Source of Funds**
(Selected calendar years 1980-1987)

Year	Total	Direct patient payments	Third parties							
			All third parties	Private health insurance	Other private funds	Government		State and local	Medicare ¹	Medicaid ²
						Total	Federal			
Amount in billions										
1980	\$219.7	\$ 63.0	\$156.7	\$ 67.5	\$2.7	\$ 86.5	\$62.5	\$ 24.0	\$35.7	\$25.2
1983	314.7	88.7	226.0	98.0	4.0	124.1	92.9	31.1	57.4	33.9
1984	340.1	95.7	244.4	105.3	4.0	135.1	101.2	33.9	63.0	36.4
1985	368.3	103.7	264.6	112.0	4.6	148.0	111.3	36.7	69.3	40.3
1986	401.6	112.6	289.0	124.6	4.8	159.6	120.3	39.2	74.6	43.6
1987	442.6	123.0	319.6	139.1	5.3	175.3	131.2	44.1	81.2	49.4
Per capita amount										
1980	\$ 934	\$268	\$ 666	\$287	\$11	\$368	\$266	\$102	3	3
1983	1,298	366	932	404	16	512	383	128	3	3
1984	1,389	391	998	430	17	552	413	138	3	3
1985	1,490	420	1,071	453	19	599	450	149	3	3
1986	1,610	452	1,159	500	19	640	482	157	3	3
1987	1,758	488	1,270	552	21	696	521	175	3	3
Percent distribution										
1980	100.0	28.7	71.3	30.7	1.2	39.4	28.4	10.9	16.2	11.5
1983	100.0	28.2	71.8	31.1	1.3	39.4	29.5	9.9	18.3	10.8
1984	100.0	28.1	71.9	31.0	1.2	39.7	29.7	10.0	18.5	10.7
1985	100.0	28.2	71.8	30.4	1.2	40.2	30.2	10.0	18.8	10.9
1986	100.0	28.0	72.0	31.0	1.2	39.7	30.0	9.8	18.6	10.9
1987	100.0	27.8	72.2	31.4	1.2	39.6	29.6	10.0	18.4	11.2

¹Subset of Federal funds.²Subset of Federal and State and local funds.³Calculation of per capita estimates is inappropriate.

NOTE: Per capita amounts based on July 1 Social Security area population estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary; Data from the Office of National Cost Estimates.

Table 5.6

Personal Health Care Expenditures by Type of Payer and Type of Expenditure, 1987 (000,000,000 omitted)

Source of payment	Total personal care	Hospital care	Physicians' services	Nursing home care	Other health services
Personal health care expenditures	\$442.6	\$194.7	\$102.7	\$40.6	\$104.6
Direct payments	123.0	18.5	26.3	20.0	58.2
Third-party payments	319.6	176.2	76.4	20.6	46.4
Private health insurance	139.1	71.9	44.6	0.4	22.2
Other private funds	5.3	2.2	0.1	0.3	3.0
Government	175.3	102.2	31.8	19.9	21.5
Medicare	81.2	53.3	22.3	0.6	5.1
Medicaid	49.4	17.8	4.4	11.8	6.0
Other	44.7	31.1	5.1	1.5	10.4

NOTE: Detail may not add to totals due to rounding.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration. *Health Care Financing Review*, Winter 1988.

Table 5.7

Personal Health Care Expenditures by Source of Payment

Year	Total	Direct patient payments	Third parties							
			All third parties	Private health insurance	Other private funds	Government				
						Total	State and local	Federal	Federal	
									Medicare	Medicaid
Amount in billions										
1965	\$ 35.9	\$ 18.5	\$ 17.3	\$ 8.7	\$0.8	\$ 7.9	\$ 4.3	NA	—	—
1966	39.7	19.6	20.0	9.1	0.8	10.1	4.9	NA	\$ 1.0	\$ 1.5
1967	44.5	19.0	25.5	9.6	0.8	15.1	5.6	NA	4.5	2.9
1968	50.3	20.7	29.6	10.9	0.9	17.8	6.4	NA	5.7	3.8
1969	57.1	23.0	34.0	12.9	0.9	20.2	7.0	NA	6.6	4.4
1970	65.4	26.5	38.9	15.3	1.1	22.4	7.9	NA	7.1	5.2
1971	72.2	28.1	44.1	17.2	1.3	25.6	8.8	NA	7.9	6.8
1972	80.5	30.6	49.9	19.0	2.0	28.8	9.9	NA	8.6	8.2
1973	89.0	33.3	55.7	21.4	2.2	32.1	11.1	NA	9.6	9.3
1974	101.3	36.2	65.1	25.1	1.5	38.5	12.8	NA	12.4	10.8
1975	117.1	38.1	79.0	31.2	1.6	46.3	14.9	NA	15.6	13.5
1976	132.8	42.0	90.8	37.6	1.8	51.4	15.3	NA	18.4	15.1
1977	149.1	46.4	102.7	43.0	2.0	57.8	16.8	NA	21.8	16.9
1978	167.4	50.7	116.7	49.1	2.1	65.5	19.2	NA	24.9	18.8
1979	189.7	55.8	133.8	56.9	2.3	74.6	21.3	NA	29.3	21.8
1980	219.7	63.0	156.7	67.5	2.7	86.5	24.0	NA	35.7	25.2
1981	254.7	72.6	182.1	78.4	3.2	100.5	26.3	NA	43.5	29.0
1982	286.5	79.6	206.9	89.9	3.5	113.5	29.5	NA	51.1	31.3
1983	314.7	88.7	226.0	98.0	4.0	124.1	31.1	NA	57.4	33.9
1984	341.1	97.8	243.3	104.9	4.3	134.1	33.2	NA	62.9	36.3
1985	368.5	103.7	264.6	112.0	4.6	148.0	36.7	111.3	69.3	40.3
1986	401.6	112.6	289.0	124.6	4.8	159.6	39.2	120.3	74.6	43.6
1987	442.6	123.0	319.6	139.1	5.3	175.3	44.1	131.2	81.2	49.4
Per capita amount										
1965	\$ 176	\$ 91	\$ 85	\$ 42	\$ 4	\$ 39	\$ 21	NA	NA	NA
1966	192	95	97	44	4	49	24	NA	NA	NA
1967	213	91	122	46	4	72	27	NA	NA	NA
1968	239	98	140	52	4	84	30	NA	NA	NA
1969	268	108	160	61	4	95	33	NA	NA	NA
1970	304	123	181	71	5	104	37	NA	NA	NA
1971	332	129	203	79	6	118	41	NA	NA	NA
1972	367	140	227	87	9	131	45	NA	NA	NA
1973	402	150	252	97	10	145	50	NA	NA	NA
1974	454	162	292	113	7	173	57	NA	NA	NA
1975	521	169	351	139	7	206	66	NA	NA	NA
1976	586	185	400	166	8	227	67	NA	NA	NA
1977	652	203	449	188	9	253	74	NA	NA	NA
1978	725	220	506	213	9	284	83	NA	NA	NA
1979	814	240	574	244	10	320	91	NA	NA	NA

Continued

1980	934	268	666	287	11	367	102	NA	NA	NA
1981	1,071	305	766	330	13	423	111	NA	NA	NA
1982	1,193	332	861	374	15	472	123	NA	NA	NA
1983	1,298	366	932	404	16	512	128	NA	NA	NA
1984	1,394	400	994	429	18	548	136	NA	NA	NA
1985	1,490	426	1,071	453	19	589	149	450	*	*
1986	1,610	452	1,159	500	19	640	157	482	*	*
1987	1,758	488	1,270	552	21	696	175	521	*	*

NOTE: Some data are revised from previous editions.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary.

*Calculation of per capita amounts is inappropriate.

Table 5.8

Personal Consumption Expenditures by Type of Product, United States, 1987

Type of product	Personal consumption expenditure (000,000,000 omitted)	Percent of total
Food (including alcohol)	526.4	17.5
Housing	467.7	15.5
Transportation	378.9	12.6
Medical care*	400.8	13.3
Household operation	362.3	12.0
Clothing, accessories and jewelry	221.5	7.4
Recreation	223.3	7.4
Personal business	208.5	6.9
Religious and welfare activities	68.1	2.3
Private education and research	51.3	1.7
Personal care	44.4	1.5
Tobacco	35.7	1.2
Foreign travel and remittances—net	16.1	0.5
Funeral and burial expenses	7.1	0.2
Total	3,012.1	100.0

*Includes all expenses for health insurance (except loss of income type).

SOURCES: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, July 1988; and Health Insurance Association of America.

Table 5.9

Ratio of Personal Consumption Expenditures for Medical Care to Disposable Personal Income and to Total Personal Consumption Expenditures in the United States
(000,000,000 omitted)

(1) Calendar year	(2) Personal consumption expenditures for medical care*	(3) Disposable personal income	(4) Total personal consumption expenditures	(5) Ratio of col. (2) to col. (3)	(6) Ratio of col. (2) to col. (4)
1950	\$ 8.8	\$ 207.5	\$ 192.1	4.3%	4.8%
1955	13.4	278.8	257.9	4.8	5.2
1960	20.6	358.9	330.7	5.7	6.2
1965	31.6	486.8	440.7	6.5	7.2
1966	34.3	525.9	477.3	6.5	7.2
1967	37.1	562.1	503.6	6.6	7.4
1968	42.5	609.6	552.5	7.0	7.7
1969	48.3	656.7	597.9	7.4	8.1
1970	55.0	715.6	640.0	7.7	8.6
1971	60.9	776.8	691.6	7.8	8.8
1972	67.6	839.6	757.6	8.1	9.0
1973	75.1	949.8	837.2	7.9	9.0
1974	84.3	1,038.3	916.5	8.1	9.2
1975	96.9	1,142.8	1,012.8	8.5	9.6
1976	109.9	1,252.6	1,129.3	8.8	9.7
1977	126.5	1,379.3	1,257.2	9.2	10.1
1978	141.0	1,151.2	1,403.5	12.2	10.0
1979	160.6	1,729.3	1,566.8	9.3	10.3
1980	185.7	1,917.9	1,732.6	9.7	10.7
1981	217.3	2,127.6	1,915.1	10.2	11.3
1982	242.7	2,261.4	2,050.7	10.7	11.8
1983	266.5	2,428.1	2,234.5	11.0	11.9
1984	296.1	2,688.6	2,430.5	11.1	12.2
1985	325.2	2,838.7	2,629.0	11.4	12.3
1986	357.0	3,019.6	2,807.5	11.8	12.7
1987	400.8	3,209.7	3,012.1	12.5	13.3

*Includes all expenses for health insurance (except loss of income type).

SOURCES: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business* (various issues); and Health Insurance Association of America.

Table 5.10

Personal Consumption Expenditures for Medical Care in the United States (000,000,000 omitted)

Calendar year	Total medical care	Hospital services	Physicians' services	Medicines and appliances	Dentists' services	Net cost of health insurance	All other medical care
1950	\$ 8.8	\$ 2.1	\$ 2.6	\$ 2.2	\$ 1.0	\$ 0.3	\$ 0.8
1955	13.4	3.4	3.8	3.0	1.5	0.6	1.1
1960	20.6	5.6	5.8	4.7	2.0	0.8	1.8
1965	31.6	8.9	8.5	6.4	2.8	1.3	3.7
1966	34.3	10.1	9.1	6.7	3.0	1.4	4.0
1967	37.1	11.8	10.0	7.0	3.4	1.3	3.7
1968	42.5	14.1	10.9	7.8	3.7	2.0	4.1
1969	48.3	17.0	12.4	8.6	4.3	1.9	4.1
1970	55.0	19.7	14.0	10.0	4.9	2.1	4.3
1971	60.9	23.2	15.3	10.5	5.1	2.6	4.2
1972	67.6	25.9	16.6	11.5	5.6	3.5	4.5
1973	75.1	28.8	18.4	12.5	6.6	3.6	5.2
1974	84.3	33.7	20.3	13.6	7.3	3.6	5.8
1975	96.9	40.1	23.5	14.9	8.2	3.2	7.0
1976	109.9	46.6	25.8	16.3	9.3	3.6	8.4
1977	126.5	53.3	29.6	17.4	10.3	5.4	10.4
1978	141.0	61.0	32.3	19.2	11.3	4.7	12.4
1979	160.6	70.0	36.3	21.6	12.3	5.6	14.8
1980	185.7	82.0	42.0	23.5	13.7	6.9	17.6
1981	217.3	96.8	49.0	25.8	16.1	7.6	22.0
1982	242.7	110.3	54.4	27.6	17.4	8.8	24.1
1983	266.5	119.6	61.1	30.3	18.5	11.0	25.8
1984	296.1	130.6	67.1	33.0	19.8	15.2	30.4
1985	325.2	140.2	73.5	36.0	21.5	17.7	36.4
1986	357.0	152.1	80.6	39.2	22.8	20.6	41.7
1987	400.8	167.4	93.9	42.9	25.0	21.9	49.8

NOTE: Some data are revised. The data exclude private expenditures in federal, state, city and other government hospitals and nursing homes. In some cases the sum of the items does not equal the "Total medical care" shown because of rounding.

SOURCE: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, various issues.

Table 5.11

Consumer Price Index for Medical Care Items in the United States

Calendar year	All medical care items	Physicians' fees	Dentists' fees	Hospital room	Drugs and prescriptions	
					Prescription drugs	Over-the- counter drugs
(Annual Average, 1967 = 100.0)						
All urban consumers						
1967	100.0	100.5	100.4	101.2	99.9	100.2
1968	106.0	106.1	105.9	114.8	98.2	102.7
1969	113.4	112.9	112.9	128.8	99.5	103.4
1970	120.6	121.4	119.3	145.4	101.2	106.2
1971	128.4	129.8	127.0	163.1	101.3	110.2
1972	132.5	133.8	132.3	173.9	100.9	111.3
1973	137.7	138.2	136.4	182.1	100.5	112.4
1974	150.5	150.9	146.8	201.5	102.9	117.5
1975	168.6	169.4	161.9	236.1	109.3	130.1
1976	184.7	188.5	172.2	268.6	115.2	138.9
1977	202.4	206.0	185.1	299.5	122.1	148.5
1978	219.4	223.1	198.1	332.4	131.6	159.0
1979	239.7	243.6	214.8	370.3	141.8	170.7
1980	265.9	269.3	240.2	418.9	154.8	188.1
1981	294.5	299.0	263.3	481.1	172.5	211.4
1982	328.7	327.1	283.6	556.7	192.7	234.2
1983	357.3	352.3	302.7	619.7	213.8	251.7
1984	379.5	376.8	327.3	670.9	234.3	267.3
1985	403.1	398.8	347.9	710.5	256.5	281.7
(Annual Average, 1982-84 = 100.0)						
1986	122.0	121.5	120.6	122.3	130.4	117.7
1987	130.1	130.4	128.8	131.1	140.8	123.9
1988	138.7	134.8	137.5	143.3	152.0	130.8

NOTE: Some data are revised.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, CPI Detailed Report, various issues.

Table 5.12

Annual Changes in Consumer Price Index

Calendar year	All items	All medical care items	Physicians' fees	Dentists' fees	Hospital room	Drugs and prescriptions	
						Prescription drugs	Over-the-counter drugs
Urban wage and clerical workers							
1947	14.4%	8.3%	6.4%	8.4%	17.3%	9.9%	—
1950	11.0	1.9	1.5	2.4	3.4	2.7	—
1955	-0.4	2.2	3.5	1.0	4.2	1.4	—
1960	1.6	3.5	2.5	2.0	6.9	-0.3	—
1965	1.7	2.5	3.6	3.1	5.6	-1.1	—
1966	2.9	4.4	5.8	3.3	10.0	-0.2	—
All urban consumers							
1967	2.9	7.1	7.6	5.5	21.2	-1.7	—
1968	4.2	6.1	5.6	5.1	13.4	-1.6	2.5%
1969	5.4	6.9	6.4	7.0	13.4	1.3	0.7
1970	5.9	6.3	7.5	5.8	12.9	1.6	2.7
1971	4.3	6.5	6.9	6.4	12.2	0.1	3.8
1972	3.3	3.2	3.1	4.2	6.6	-0.4	1.0
1973	6.2	3.9	3.3	3.1	4.7	-0.4	1.0
1974	11.0	9.3	9.2	7.6	10.7	2.4	4.5
1975	9.1	12.0	12.3	10.3	17.2	6.2	10.7
1976	5.8	9.5	11.3	6.4	13.8	5.4	6.8
1977	6.5	9.6	9.3	7.5	11.5	6.0	6.9
1978	7.6	8.4	8.3	7.0	11.0	7.8	7.1
1979	11.3	9.3	9.2	8.4	11.4	7.7	7.4
1980	13.5	10.9	10.6	11.8	13.1	9.2	10.2
1981	10.4	10.8	11.0	9.6	14.9	11.5	12.4
1982	6.2	11.6	9.4	7.7	15.7	11.7	10.8
1983	3.2	8.7	7.7	6.7	11.3	11.0	7.5
1984	4.3	6.2	6.9	8.1	8.3	9.6	6.2
1985	3.6	6.2	5.8	6.3	5.9	9.5	5.4
1986	1.9	7.5	7.3	5.6	6.0	8.6	4.9
1987	3.7	6.6	7.4	6.7	7.2	8.0	5.3
1988	4.1	6.5	7.2	6.8	9.2	7.9	5.5

NOTE: Some data are revised.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, *CPI Detailed Report*, various issues.

Table 5.13

Consumer Price Index in the United States

Calendar year	All items	Food	Apparel	Housing	Transportation	Medical care	Entertainment	Other goods and services
(Annual Average, 1967 = 100.0)								
All urban consumers								
1967	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1968	104.2	103.6	105.4	104.0	103.2	106.1	105.7	105.2
1969	109.8	108.9	111.5	110.4	107.1	113.4	110.9	110.4
1970	116.3	114.9	116.1	118.1	112.7	120.6	116.7	116.8
1971	121.3	118.4	119.8	123.4	118.6	128.4	122.9	122.4
1972	125.3	123.5	122.3	128.2	119.9	132.5	126.5	127.5
1973	133.1	141.4	126.8	133.7	123.8	137.7	130.0	132.5
1974	147.7	161.7	136.2	148.8	137.7	150.5	139.8	142.0
1975	161.2	175.4	142.3	164.4	150.6	168.6	152.2	153.9
1976	170.5	180.8	147.6	174.5	165.5	184.7	159.8	162.7
1977	181.5	192.2	154.2	186.5	177.2	202.4	167.7	172.2
1978	195.4	211.4	159.6	202.8	185.5	219.4	176.6	183.3
1979	217.5	234.5	166.6	227.6	212.0	239.7	188.5	196.7
1980	246.8	254.6	178.4	263.2	249.7	265.9	205.3	214.5
1981	272.4	274.6	186.9	293.4	280.0	294.5	221.4	235.7
1982	289.2	285.7	191.8	314.6	291.5	328.7	235.8	259.9
1983	298.4	291.7	196.5	322.9	298.4	357.3	246.0	288.3
1984	311.2	302.9	200.2	336.3	311.7	379.5	255.1	307.7
1985	322.2	309.8	206.0	349.6	319.9	403.1	265.0	326.6
(Annual Average, 1982-84 = 100.0)								
1986	109.6	108.9	105.9	110.9	102.3	122.6	111.6	181.4
1987	113.6	113.5	110.6	114.2	105.4	130.1	115.3	128.5
1988	118.3	118.2	115.4	118.5	108.7	138.6	120.3	137.0

NOTE: Some data are revised.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, CPI Detailed Report, various issues.

Table 5.14

Average Cost to Community Hospitals Per Patient Day and Per Patient Admission; Average Length of Stay in Community Hospitals in the United States

Calendar year	Average cost to hospital per adjusted inpatient day*			Average length of hospital stay (days)	Average cost to hospital per adjusted admission*
	Total	Payroll	Other		
1946	\$ 9.39	\$ 4.98	\$ 4.41	9.1	\$ 85.45
1950	15.62	8.86	6.76	8.1	126.52
1955	23.12	14.26	8.86	7.8	180.34
1960	32.23	20.08	12.15	7.6	244.95
1961	34.98	21.54	13.44	7.6	265.85
1962	36.83	22.79	14.04	7.6	279.91
1963	38.91	24.01	14.90	7.7	299.61
1964	41.58	25.26	16.32	7.7	320.17
1965	44.48	27.44	17.04	7.8	346.94
1966	48.15	29.41	18.74	7.9	380.39
1967	54.08	32.44	21.64	8.3	448.86
1968	61.38	36.61	24.77	8.4	515.59
1969	70.03	41.36	28.67	8.3	581.25
1970	81.01	47.30	33.71	8.2	664.28
1971	92.31	53.80	38.51	8.0	738.48
1972	105.30	59.80	45.50	7.9	831.70
1973	102.40	57.00	45.40	7.8	798.70
1974	113.60	61.90	51.70	7.8	886.10
1975	133.80	70.90	62.90	7.7	1,030.30
1976	151.80	78.00	73.60	7.7	1,168.90
1977	174.00	87.40	86.60	7.6	1,322.40
1978	194.34	96.59	97.75	7.6	1,474.21
1979	217.34	107.37	109.97	7.6	1,641.48
1980	245.12	119.13	125.99	7.6	1,850.96
1981	284.33	138.18	146.15	7.6	2,171.20
1982	327.37	158.12	169.25	7.6	2,500.52
1983	369.49	176.25	193.24	7.6	2,789.18
1984	411.10	194.04	217.06	7.3	2,995.38
1985	460.19	213.07	247.12	7.1	3,244.74
1986	500.81	226.87	273.94	7.1	3,532.51
1987	538.96	240.91	298.05	7.2	3,850.16

*Adjusted expense per admission is the average expense to the hospital in providing care for one patient stay. These expenses are derived by subtracting outpatient expenses from total expenses, and dividing the resulting amount by total admissions. Adjusted expense per inpatient day covers expense of inpatient care only and is derived by dividing expense by inpatient days.

NOTE: Data prior to 1972 include hospital units of institutions. Total expenses include payroll expenses; employee benefits; professional fees; depreciation expense; supplies and purchased services. Payroll expenses include physicians' and dentists' salaries; other personnel. Prior to 1972 payroll expenses also included medical and dental interns and residents, trainees in medical technology and administration. Data for 1973-1985 have been adjusted to include data for outpatients on an inpatient equivalency basis.

SOURCES: American Hospital Association, *Hospital Statistics* (various annual editions); and Health Insurance Association of America.

Table 5.15

Community Hospital Statistics, 1987

State	Average cost to hospital per day	Average length of hospital stay	Average cost to hospital per stay
Alabama	\$460.65	7.0	\$3,221.61
Alaska	892.02	5.7	5,056.92
Arizona	710.37	5.9	4,166.85
Arkansas	413.82	6.6	2,738.06
California	741.91	6.4	4,755.33
Colorado	591.58	6.9	4,039.75
Connecticut	612.36	7.3	4,445.79
Delaware	582.64	6.9	3,877.81
District of Columbia	722.13	7.8	5,636.28
Florida	582.66	7.0	4,083.45
Georgia	456.17	6.9	3,116.21
Hawaii	512.48	7.9	4,106.04
Idaho	444.14	6.5	2,897.83
Illinois	575.25	7.4	4,227.53
Indiana	531.42	6.5	3,434.65
Iowa	401.75	8.2	3,289.93
Kansas	422.28	7.8	3,275.62
Kentucky	448.49	6.4	2,833.76
Louisiana	565.51	6.3	3,518.45
Maine	435.76	7.9	3,425.75
Maryland	516.36	7.1	3,678.50
Massachusetts	605.28	7.7	4,623.76
Michigan	607.34	7.3	4,375.99
Minnesota	426.82	9.0	3,833.96
Mississippi	354.17	6.8	2,422.58
Missouri	546.44	7.5	4,088.85
Montana	330.69	9.4	3,094.83
Nebraska	370.34	9.6	3,538.82
Nevada	765.93	6.0	4,635.05
New Hampshire	496.19	6.4	3,137.12
New Jersey	452.29	7.5	3,372.95
New Mexico	578.08	5.7	3,236.46
New York	493.69	9.2	4,519.58
North Carolina	442.04	7.2	3,168.17
North Dakota	368.56	10.1	3,596.25
Ohio	571.55	6.9	3,896.78
Oklahoma	518.14	6.7	3,465.04
Oregon	655.24	5.3	3,451.43
Pennsylvania	544.16	7.5	4,059.62
Rhode Island	501.55	8.0	4,009.38
South Carolina	433.73	7.0	3,059.91
South Dakota	317.59	9.2	2,886.71
Tennessee	468.88	7.0	3,247.19
Texas	565.15	6.2	3,495.58
Utah	646.62	5.4	3,453.21
Vermont	444.62	7.4	3,274.16
Virginia	475.65	7.1	3,357.79
Washington	630.11	5.7	3,602.43
West Virginia	482.56	6.8	3,103.22
Wisconsin	446.26	7.5	3,326.53
Wyoming	403.39	7.1	2,848.44
Average U.S.	536.96	7.2	3,850.16

SOURCE: Hospital Statistics, copyright 1988 by the American Hospital Association.

Table 5.16

Comparison of Hospital Semiprivate Room Charges by State and Territory*

States and Territories	January 1987	January 1988	Percent change
Alabama	\$176.11	\$187.00	6.2%
Alaska	317.82	330.66	4.0
Arizona	232.88	251.22	7.9
Arkansas	154.81	158.94	2.7
California	328.21	360.54	9.9
Colorado	242.08	261.25	7.9
Connecticut	333.29	344.28	3.3
Delaware	305.00	325.00	6.6
District of Columbia	422.74	449.05	6.2
Florida	202.06	217.94	7.9
Georgia	151.89	161.91	6.6
Hawaii	241.72	257.25	6.4
Idaho	229.95	249.67	8.6
Illinois	265.24	275.55	3.9
Indiana	205.52	223.81	8.9
Iowa	192.79	201.96	4.8
Kansas	200.74	216.23	7.7
Kentucky	198.65	215.32	8.4
Louisiana	199.69	208.56	4.4
Maine	231.86	257.20	10.9
Maryland	213.25	231.69	8.6
Massachusetts	286.47	312.04	8.9
Michigan	279.67	293.78	5.0
Minnesota	223.31	243.59	9.1
Mississippi	124.80	140.50	12.6
Missouri	213.47	225.71	5.7
Montana	214.22	218.73	2.1
Nebraska	172.63	181.88	5.4
Nevada	223.39	223.92	0.2
New Hampshire	220.77	238.28	7.9
New Jersey	212.32	228.73	7.7
New Mexico	232.13	233.88	0.8
New York	254.19	265.69	4.5
North Carolina	156.68	174.45	11.3
North Dakota	183.97	195.04	6.0
Ohio	261.19	275.65	5.5
Oklahoma	178.49	187.72	5.2
Oregon	263.46	286.65	8.8
Pennsylvania	284.25	301.32	6.0
Puerto Rico	131.22	139.77	6.5
Rhode Island	244.20	274.86	12.6
South Carolina	145.23	159.48	9.8
South Dakota	174.67	181.85	4.1
Tennessee	161.83	172.62	6.7

Continued

Texas	183.40	198.78	8.4
Utah	234.23	242.48	3.5
Vermont	257.02	284.48	10.7
Virginia	180.99	195.01	7.7
Washington	268.39	281.04	4.7
West Virginia	180.70	196.00	8.5
Wisconsin	171.56	185.83	8.3
Wyoming	177.14	188.83	6.6
Average U.S.	\$238.78	\$254.87	6.7%

*Matching data only.

SOURCE: Health Insurance Association of America, Survey of Hospital Semi-Private Room Charges as of January 1968.

Table 5.17

Fees for Surgical and OBG Procedures in the United States, 1988

Specialty	Fees	Specialty	Fees
General Surgeons		Neurosurgeons	
Appendectomy	\$ 784	Wrist ganglionectomy	\$ 450
Cholecystectomy	1,200	Cranioplasty	2,500
Inguinal hernia (unilateral)	751	Craniotomy	3,500
Modified radical mastectomy	1,401	Lumbar laminectomy	2,500
OBG Specialists		Plastic Surgeons	
Complete OB care (usual and routine)	1,344	Complete rhinoplasty	2,199
Total hysterectomy	1,600	Facial rhytidectomy	3,001
D&C (diagnostic)	401	Breast augmentation (bilateral)	2,001
D&C (therapeutic)	450	Dermabrasion of facial scar	401
Thoracic Surgeons		Excision of lipoma	301
Cor/art bypass with three autogenous graphs	4,500	Orthopedic Surgeons	
Lobectomy	2,160	Wrist ganglionectomy	451
Insert pacemaker	1,300	Diagnostic knee arthroscopy	601
Thoracentesis	150	Excision of knee cartilage	1,301
Dilation of esophagus	250		

SOURCE: Medical Economics magazine, October 3, 1988. Copyright © 1988 and published by Medical Economics Company, Inc., at Oradell, N.J. 07649. Reprinted by permission.

Table 5.18

Median Office Visit Fees by Physician Specialty and Type of Community, 1988

Specialty	First office visits			Office revisits		
	Urban	Suburban	Rural	Urban	Suburban	Rural
FPs	\$34	\$35	\$29	\$26	\$27	\$23
GPs	36	31	26	26	26	21
All surgical specialists	51	50	40	31	31	25
All nonsurgical specialists (except FPs & GPs)	51	46	36	31	31	25

SOURCE: Medical Economics magazine, October 3, 1988. Copyright © 1988 and published by Medical Economics Company, Inc., at Oradell, N.J. 07649. Reprinted by permission.

Table 5.19

Regional Variations in Median Physician Fees, 1988

Specialty	First office visits			
	West	Midwest	South	East
FPs	\$37	\$29	\$ 31	\$31
GPs	40	26	30	35
Internists	56	36	46	51
OBG specialists	67	50	51	56
Pediatricians	42	33	36	36
General surgeons	50	31	39	41
Neurosurgeons	151	91	100	*
Orthopedic surgeons	56	40	45	61
Plastic surgeons	45	36	44	61
Thoracic surgeons	*	51	60	78
All surgical specialists	60	41	46	56
All nonsurgical specialists (except FPs and GPs)	60	36	41	50

Specialty	Office revisits			
	West	Midwest	South	East
FPs	\$30	\$23	\$25	\$26
GPs	30	21	23	26
Internists	36	26	30	31
OBG specialists	40	30	31	40
Pediatricians	31	26	26	30
General surgeons	30	23	26	30
Neurosurgeons	40	30	35	*
Orthopedic surgeons	33	25	27	36
Plastic surgeons	26	25	26	31
Thoracic surgeons	*	25	27	38
All surgical specialists	35	26	28	35
All nonsurgical specialists (except FPs and GPs)	36	26	30	35

*Insufficient sample.

SOURCE: Medical Economics magazine, October 3, 1988. Copyright © 1988 and published by Medical Economics Company, Inc., at Oradell, N.J. 07649. Reprinted by permission.

Table 5.20

Total Cost of Having a Baby, 1986

	Usual birth			Cesarean		
	Average physicians' fees	Hospital and medical	Total cost	Average physicians' fees	Hospital and medical	Total cost
Northeast						
Metropolitan	\$ 980	2,020	\$3,000	\$1,210	\$3,070	\$4,280
Nonmetropolitan	960	1,650	2,610	1,240	2,910	4,150
Total	980	1,900	2,880	1,220	2,980	4,200
South						
Metropolitan	840	1,670	2,510	1,100	2,920	4,020
Nonmetropolitan	760	1,560	2,320	1,010	2,860	3,870
Total	800	1,590	2,390	1,060	2,890	3,950
Midwest						
Metropolitan	760	1,970	2,730	1,020	3,520	4,540
Nonmetropolitan	640	1,610	2,250	880	3,100	3,980
Total	690	1,770	2,460	930	3,290	4,220
West						
Metropolitan	1,090	2,000	3,090	1,390	4,050	5,440
Nonmetropolitan	820	1,440	2,260	1,110	3,270	4,380
Total	950	1,780	2,730	1,250	3,680	4,930
US						
Metropolitan	900	1,900	2,800	1,110	3,340	4,450
Nonmetropolitan	760	1,580	2,340	970	3,070	4,040
Total	830	1,730	2,560	1,040	3,230	4,270

SOURCE: The Cost of Having a Baby, Health Insurance Association of America.

NOTE: Costs are based on birth in labor and delivery room in hospital and exclude pediatrician's routine, in-hospital newborn care fee, circumcision fee and anesthesiologist's professional fee.

Table 5.21

Certain Costs of Accidents by Class, 1987 (000,000,000 omitted)

Cost	Total*	Motor vehicle	Work	Home	Public nonmotor vehicle
Total	\$133.2	\$64.7	\$42.4	\$16.7	\$11.5
Wage loss	34.6	18.8	7.6	5.0	4.8
Medical expense	23.2	4.6	6.7	7.2	5.2
Insurance administration	27.6	20.6	5.8	0.7	0.5
Fire loss	7.0	†	2.2	3.8	1.0
Motor vehicle property damage	20.7	20.7	†	†	†
Indirect work loss	20.1	†	20.1	†	†

*Duplications between work and motor vehicle and home and motor vehicle are eliminated in the totals.

†Not included.

SOURCE: Accident Facts, 1988 edition. Copyright © 1988 by National Safety Council. Reprinted by permission.

NOTE: Cost estimates are not comparable with those of previous years. As additional or more precise data become available they are used from that year forward, but previously estimated figures are not revised. Insurance administration estimating procedures were revised for the 1987 edition. Home and public insurance administration costs may include costs of administering medical treatment claims for some motor vehicle injuries filed through health insurance plans.

Table 5.22

Ten Most Frequent Surgical Procedures

(Patients Discharged from Short-Stay Hospitals, 1986)		
Procedure	Numbers in 1000s	Length of stay (days)
Biopsy	1,412	8.5
Cesarean section	906	5.0
Hysterectomy	644	5.9
Repair OB laceration	612	2.7
Operations on spinal cord and spinal canal	571	8.2
Excision of skin lesions	565	10.5
Arthroplasty of joints	537	10.4
Cholecystectomy	502	7.9
Oophorectomy and salpingo-oophorectomy	502	*
Dilation and curettage of uterus	472	2.2

SOURCE: Division of Health Care Statistics, National Center for Health Statistics, 1986.

*Incomplete data.

NOTE: Average length of stay data are for first-listed operations. For example, average length of stay for biopsy and excision of skin lesions may also include days in hospital for subsequent operative procedures.

Chapter 6

DISABILITY AND HEALTH CARE UTILIZATION

◆ Disability

Disability income insurance is a form of health insurance provided by group and individual policies, and by specific government programs designed to replace income for insured persons who become disabled and are unable to work because of illness, injury or disease. Disability rates for both acute and chronic health conditions measured by work-loss days, restricted activity days and disability days vary by social and economic characteristics.

Table 6.1 shows that the probability of a male becoming disabled between the ages of 20 and 30 is 1.3 percent, but between the ages of 20 and 60 this increases to 19.1 percent. Females are less prone to disability during their lifetimes and have only a 15.3 percent chance of becoming disabled between 20 and 60 years of age. This data is based on males and females who attained the age of 20 years in 1986.

Table 6.2 shows that workers with higher incomes have fewer days of disability from acute health conditions. Marked differences in the number of disability days are also found in relation to the sex of the worker. Females averaged 7.7 days and males averaged only 6.1 days of restricted activity per person in 1987.

Among the geographical regions of the United States, the West had more restricted activity days (16 per person) due to chronic and acute conditions. The Northeastern region reported 5.2 work-loss days per person, the highest number recorded in any of the regions across the country. (Table 6.3)

Acute Conditions

Some 347 million workdays (Table 6.4) were lost in 1987 as a result of all acute health conditions. This was an average of 3.1 days off the job for each worker in the metropolitan statistical areas of the nation. Men were more often unable to work due to injuries and women lost more workdays due to respiratory infections.

Chronic Conditions

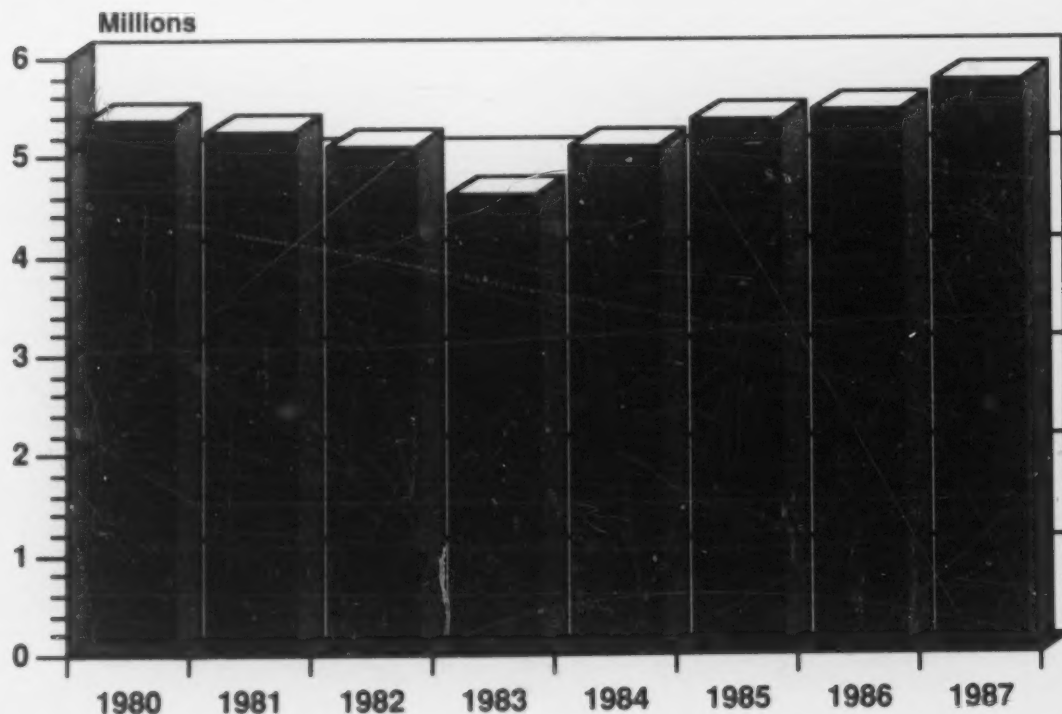
In 1987, 32 million persons, 13.5 percent of the U.S. civilian noninstitutional population (238.6 million), suffered some activity limitation because of one or more chronic conditions. Twenty-two million, or 9.2 percent of all Americans, suffered limitation of their major activity.

Occupational Injuries and Illness

According to the U.S. Department of Labor's latest survey, approximately 5.8 million work-related injuries occurred in 1987. More than 49 million workdays (Table 6.5) were lost because of work-related injuries in that year, nearly 4 million more than in 1986.

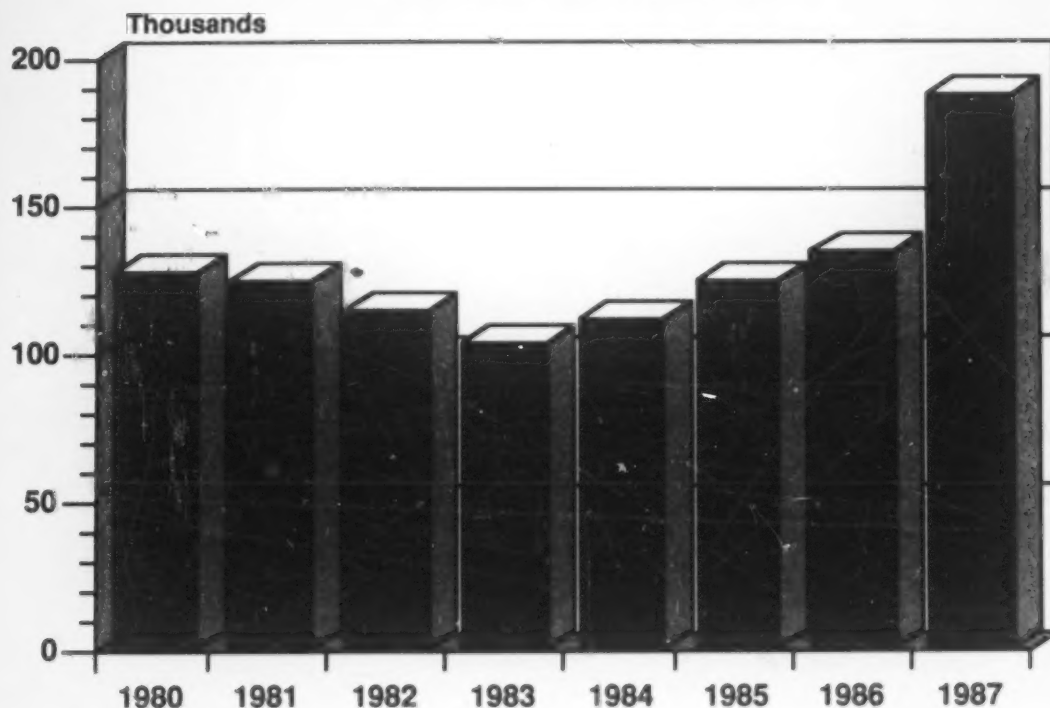
In one year, the cases of occupational illnesses rose from 137,000 in 1986 to 190,000 in 1987.

Work-Related Injuries in the Private Sector



SOURCE: U.S. Department of Labor, Bureau of Labor Statistics.

Work-Related Illnesses in the Private Sector



SOURCE: U.S. Department of Labor, Bureau of Labor Statistics.

◆ Social Security Disability Insurance Program

The Social Security Disability Insurance program is the largest federal income program for disabled persons. Table 6.6 shows the growth of this program from 1965 to 1987.

In 1978, more workers and dependents received benefits through Social Security than any year since the program began. In 1987, 2,786,000 disabled workers collectively received a total of \$20.5 billion in benefits through the program.

Table 6.1

**Probabilities of Disability for Insured Workers Attaining
Age 20 in 1986**

To Age	Probability of Insured Disability from Age 20	
	Males	Females
21	0.1%	0.0%
25	0.5	0.3
30	1.3	0.7
35	2.3	1.5
40	3.5	2.6
45	5.2	4.1
50	7.8	6.4
55	12.0	9.9
60	19.1	15.3
65	29.2	22.1
66	30.8	23.1
67	32.2	24.0

SOURCE: U.S. Department of Health and Human Services, Social Security Division.

Table 6.2

Disability Due to Acute Conditions by Social and Economic Characteristics in the United States, 1987
(Days per person)

Characteristics	Restricted activity	Bed disability	Work-loss (18 yrs. & over)
Sex			
Male	6.1	2.5	2.8
Female	7.7	3.4	3.4
Family Income			
Under \$10,000	9.1	4.4	4.1
\$10,000-19,999	7.3	3.3	NA
\$20,000-34,999	6.8	2.8	NA
\$35,000 and over	5.8	2.4	NA
Place of Residence			
Metropolitan Statistical Area	6.7	3.1	3.1
Other Statistical Area	7.1	3.0	3.0
Age			
Under 5 years	9.4	4.4	—
5-17 years	6.5	2.9	—
18-24 years	6.9	3.0	3.4
25-44 years	6.3	2.7	3.1
45-64 years	6.1	2.6	2.9
65 years and older	8.1	3.4	—

NA = Not available

NOTE: The data refer to the civilian, noninstitutional population. A "Restricted activity day" is one on which a person cuts down on his usual activities for the whole of that day because of an illness or injury. A "Bed disability day" is one on which a person stays in bed for all or most of the day because of a specific illness or injury. A "Work-loss day" is a day on which a currently employed person, 18 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. "Family income" includes the total income of each member of the family.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the National Health Interview Survey: United States 1987*.

Table 6.3

Selected Health Characteristics by Geographic Region in the United States, 1987 (Days/visits per person)

Characteristics	Geographic region			
	Northeast	Midwest	South	West
Restricted activity days*	13.6	13.0	15.0	16.0
Days of bed disability*	6.2	5.4	6.9	5.9
Work-loss days*	5.2	5.0	5.0	5.1
Physician visits	5.2	5.7	5.2	5.5

*Chronic and acute conditions.

NOTE: The data refer to the civilian, noninstitutional population. A "Restricted activity day" is one on which a person cuts down on his usual activities for the whole of that day because of an illness or injury. A "Bed disability day" is one on which a person stays in bed for all or most of the day because of a specific illness or injury. A "Work-loss day" is a day on which a currently employed person, 18 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. A "Physician visit" is a consultation with a physician, in person or by telephone, for examination, diagnosis, treatment or advice. A "Dental visit" is any visit to a dentist's office for treatment or advice.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the National Health Interview Survey: United States 1987*.

Table 6.4

Workdays Lost Due to Acute Conditions in the United States, 1987

	Number of work-loss days (000,000)			Work-loss days per employed person		
	All ages 18 and over	Age 18-44	Age 45 and over	All ages 18 and over	Age 18-44	Age 45 and over
Acute conditions						
Both Sexes						
All acute conditions	347	252	95	3.1	3.2	2.9
Infective and parasitic diseases	25	22	3	0.8	0.3	0.1
Respiratory conditions	111	81	30	1.1	1.1	1.0
Digestive system conditions	16	12	3	0.2	2.1	1.1
Injuries	119	85	34	1.1	1.1	1.0
All other acute conditions	18	11	17	0.2	0.1	0.2
Male						
All acute conditions	175	124	51	2.8	2.9	2.7
Infective and parasitic diseases	10	9	.9	0.2	0.2	0.1
Respiratory conditions	54	39	15	0.8	0.9	0.7
Digestive system conditions	8	6	3	0.2	0.1	0.2
Injuries	77	57	20	1.2	1.4	1.1
All other acute conditions	8	5	3	0.2	0.1	0.2
Female						
All acute conditions	172	128	44	3.4	4.0	3.1
Infective and parasitic diseases	15	13	2	0.3	0.4	0.2
Respiratory conditions	57	42	15	1.4	1.2	1.1
Digestive system conditions	7	7	.8	0.2	0.2	0.2
Injuries	42	28	14	0.8	0.5	1.0
All other acute conditions	9	6	4	0.2	0.2	0.3

NOTE: The data refer to the civilian, noninstitutional population. An acute condition is one which lasted less than 3 months and which involved either medical attention or restricted activity. A "Work-loss day" is a day on which a currently employed person, 18 years of age and over, did not work at least half of his normal workday because of a specific illness or injury. In some cases the sum of the items does not equal the total shown, because of rounding.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Current Estimates from the National Health Interview Survey: United States 1987*.

Table 6.5

Number of Occupational Injuries and Illnesses, and Lost Workdays, Private Sector, by Industry Division, United States, 1986 and 1987 (In thousands)

Industry division	Total cases*		Lost workday cases		Lost workdays	
	1986	1987	1986	1987	1986	1987
Injuries and illnesses						
Private sector**	5,629.0	6,035.9	2,590.3	2,801.6	46,725.7	50,941.4
Agriculture, forestry and fishing**	90.3	99.6	44.9	50.8	756.4	837.7
Mining†	57.4	61.5	32.2	35.1	979.5	1,039.5
Construction	647.1	638.3	293.1	295.0	5,707.5	5,895.3
Manufacturing	1,948.8	2,212.6	861.3	976.5	15,609.1	17,689.9
Durable goods	1,213.8	1,385.6	526.6	597.0	9,572.7	10,699.2
Nondurable goods	735.0	827.0	334.7	379.5	6,036.4	6,990.7
Transportation and public utilities	406.0	429.2	238.2	250.6	5,025.4	5,497.2
Wholesale and retail trade	1,431.6	1,470.5	621.5	654.8	10,093.4	10,725.2
Wholesale trade	391.6	408.7	197.4	205.4	3,381.8	3,525.7
Retail trade	1,040.1	1,061.8	424.1	449.4	6,711.6	7,199.4
Finance, insurance and real estate	115.4	115.3	50.6	51.2	966.5	832.9
Services	932.4	1,009.0	448.6	487.5	7,587.8	8,423.6
Injuries						
Private sector**	5,492.0	5,845.5	2,533.2	2,721.3	45,383.8	49,069.6
Agriculture, forestry and fishing**	86.4	95.0	43.7	49.3	747.0	823.4
Mining†	55.7	59.3	31.6	34.6	968.1	1,028.9
Construction	641.2	631.2	290.4	292.3	5,657.0	5,854.2
Manufacturing	1,865.1	2,087.2	825.4	923.2	14,691.7	16,293.7
Durable goods	1,165.6	1,306.9	505.9	565.7	9,017.9	9,869.2
Nondurable goods	699.5	780.3	319.6	357.5	5,673.9	6,424.6
Transportation and public utilities	400.6	422.5	235.7	247.5	4,972.6	5,442.7
Wholesale and retail trade	1,419.9	1,456.2	616.8	648.3	9,999.3	10,592.8
Wholesale trade	367.1	403.8	195.8	203.3	3,352.0	3,485.0
Retail trade	1,032.8	1,052.4	421.0	445.0	6,647.3	7,107.7
Finance, insurance and real estate	112.7	112.2	49.1	49.9	902.0	802.8
Services	910.4	981.9	440.4	476.0	7,446.0	8,231.1
Illnesses						
Private sector**	136.9	190.4	57.1	80.3	1,341.9	1,871.7
Agriculture, forestry and fishing**	3.9	4.6	1.2	1.5	9.4	14.4
Mining†	1.6	2.2	.5	.5	11.4	10.6
Construction	5.8	7.0	2.7	2.7	50.5	41.1
Manufacturing	83.7	125.4	35.9	53.3	917.3	1,396.2
Durable goods	48.2	78.7	20.8	31.3	554.8	830.0
Nondurable goods	35.4	46.7	15.1	22.0	362.5	566.2
Transportation and public utilities	5.5	6.7	2.5	3.1	52.8	54.5
Wholesale and retail trade	11.8	14.3	4.7	6.5	94.1	132.4
Wholesale trade	4.5	4.8	1.6	2.1	29.8	40.7
Retail trade	7.3	9.5	3.1	4.4	64.4	91.7
Finance, insurance and real estate	2.7	3.1	1.5	1.2	64.5	30.1
Services	22.0	27.1	8.2	11.6	141.8	192.5

* Includes fatalities.

** Excludes farms with fewer than 11 employees.

† Excludes independent mining contractors.

NOTE: Because of rounding, components may not add to the totals. The difference between the number of total cases and the sum of the lost workday cases and nonfatal cases without lost workdays may not equal the fatality.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics.

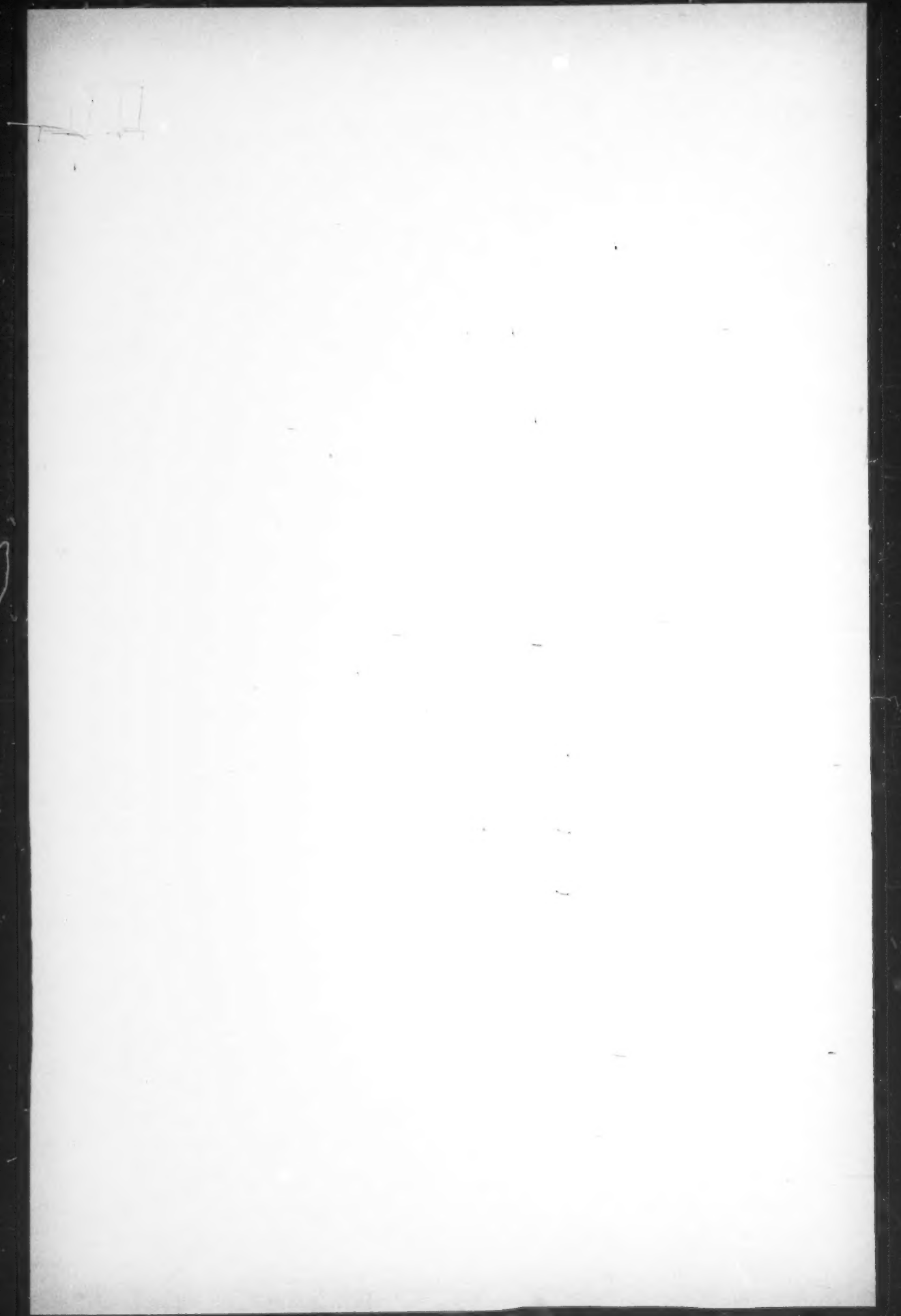
Table 6.6

Growth in the Social Security Disability Program

Year	Number of workers insured for disability (000,000 omitted)	Disabled workers receiving benefits		Total disability insurance beneficiaries (000 omitted)	Total cash benefits paid for disability (000,000,000 omitted)
		Number (000 omitted)	Number per 100,000 insured workers		
1965	53.3	988.1	1,954	1,739.1	\$ 1.6
1966	55.0	1,097.2	1,995	1,970.3	1.8
1967	55.7	1,193.1	2,142	2,140.2	1.9
1968	56.9	1,295.3	2,276	2,335.1	2.3
1969	70.1	1,394.3	1,989	2,487.5	2.5
1970	72.4	1,492.9	2,062	2,665.0	3.1
1971	74.5	1,647.7	2,212	2,930.0	3.8
1972	76.1	1,832.9	2,409	3,271.5	4.5
1973	77.8	2,016.9	2,592	3,559.0	5.7
1974	80.4	2,236.9	2,782	3,911.3	6.9
1975	83.3	2,488.8	2,988	4,352.2	8.4
1976	85.3	2,670.2	3,130	4,623.8	10.0
1977	87.0	2,837.4	3,261	4,860.4	11.5
1978	89.3	2,879.8	3,225	4,868.5	12.5
1979	93.7	2,870.6	3,064	4,777.4	13.7
1980	98.0	2,858.7	2,917	4,682.2	15.4
1981	100.5	2,776.5	2,763	4,456.3	17.2
1982	102.4	2,603.6	2,543	3,973.5	17.3
1983	103.6	2,569.0	2,480	3,812.9	17.5
1984	106.6	2,596.5	2,436	3,821.8	17.9
1985	109.2	2,656.5	2,433	3,907.2	18.8
1986	111.3	2,727.4	2,450	3,993.3	19.9
1987	113.3	2,786.0	2,458	4,045.1	20.5

NOTE: Number of disabled workers in current payment status as of December 31 of the year indicated. Insured workers as of January 1 of the year indicated.

SOURCES: U.S. Department of Health and Human Services; Social Security Administration.



Chapter 7

TRENDS IN UTILIZATION OF HOSPITAL AND MEDICAL SERVICES

Community hospitals (defined as nonfederal, short-term, general and special hospitals), providing general medical care to the public, account for 82 percent of all hospitals and 92 percent of all the hospital admissions in the United States.

According to the 1988 edition of *Hospital Statistics*, a publication of the AHA, community hospital admissions reached 31.6 million in 1987, 86,578 on each day of the year. Hospitals also reported 245 million outpatient visits, which indicates an increased use of new facilities for the treatment of medical and psychiatric patients on an outpatient basis.

The increasing use of ambulatory care as an alternative to hospitalization is evident in the proliferation of ambulatory care centers across the United States and the number of patient visits to these centers. The number of centers increased from approximately 600 in 1982 to 3,800 in four years' time. The number of patient visits to these centers jumped from under 5 million in 1982 to 60 million in 1986.

Hospice, a new concept of palliative care for the dying, began in the United States in 1973, with the establishment of the first facility of this type in New Haven, Connecticut. Hospices must be certified by the Department of Health and Human Services only if they are going to be reimbursed by Medicare. This alternative to regular hospitalization for the dying is available at 15 percent of the community hospitals and at an increasing number of freestanding facilities across the United States.

Since 1980, community hospitals have increased their patient services and the number of special beds. (Table 7.4) New facilities reflect a greater emphasis on nonacute care and outpatient services.

◆Utilization by Diagnosis

Information from the National Center for Statistics indicates that in 1987 women were hospitalized more often than men for surgery. (Table 7.5) With the exception of obstetrical procedures for women, operations on the digestive system were the most common type of procedure performed on both sexes.

According to the National Center for Health Statistics, the most frequent diagnoses for patients under 15 years of age were pneumonia, acute respiratory infections, asthma and chronic disease of the tonsils and adenoids. Psychoses, fractures, abortions and ectopic pregnancies were the most frequent diagnoses of patients 15-44 years of age, excluding females with deliveries. Patients 45-64 years of age were hospitalized most frequently for heart disease and the most common diagnoses for those 65 years of age and over were heart disease and malignant neoplasms. (Table 7.6)

◆ Physician Visits

Estimates from the National Health Interview Survey, by the Department of Health and Human Services, show that Americans made 730 million visits to physicians' offices in 1987, an average of 3.1 visits per person. Overall visits to all places of contact totaled 1.3 billion, an average of 5.4 per person. (Table 7.7)

Blacks, aged 45 years or older, visited their physicians more than whites, averaging 7.3 per person in the age group 45-65 years of age and 9.4 per person for those 65 years and over. People with incomes under \$10,000 a year averaged nearly two more visits per person than people who had incomes of \$10,000 to \$19,999 during 1987.

◆ Morbidity and Mortality

Despite medical breakthroughs and environmental changes, cardiovascular-renal diseases and cancer are still the leading causes of death in the United States. Deaths from cancer increased slightly in 1987 to 22.4 percent while deaths from heart diseases and related illnesses continued to decrease as they have since 1960.

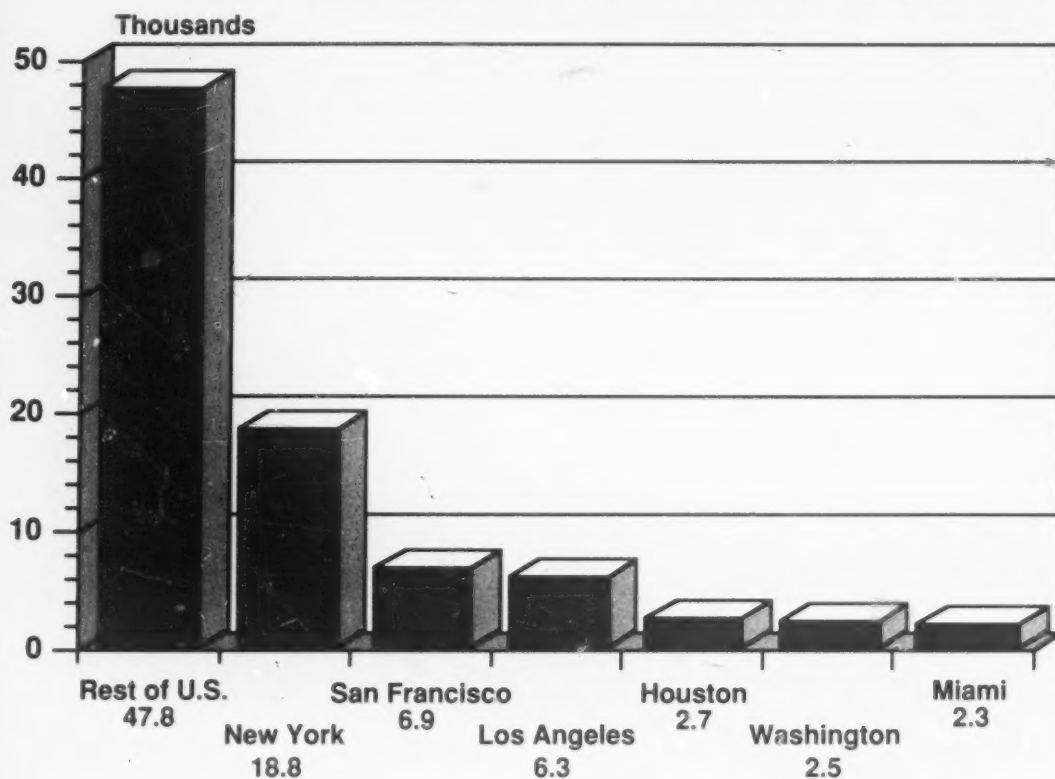
Life expectancy at birth increased slightly for males to 71.5 years, and remained the same for females at 78.3 years in 1987. (Table 7.8)

The death rate in the United States has been affected in the last few years by acquired immune deficiency syndrome (AIDS). The AIDS epidemic ranks as one of the nation's worst public health disasters. The new disease has no known cure and is invariably fatal. Since 1981, the Centers for Disease Control in Atlanta have reported more than 87,300 cases of AIDS and estimate that 1.5 million Americans are infected with the AIDS virus.

Although the overall crude death rate in the United States has decreased over the years due to improvements in public health, job safety, rising standards of living and discoveries within the medical community, it remained the same (8.7 per 1,000 population) in 1987 as it was in 1986.

AIDS Cases in Major Cities in the U.S.

(Total cases in the thousands reported through February 1989)



**Total
Cases
87,300**

**Total
Deaths
49,976**

SOURCE: Centers for Disease Control, Atlanta, Georgia.

Technically adjusted for the changing proportion of people at specified ages in the U. S. population, the death rate, 5.4 per thousand in 1987, is the same as it was in 1986 and continues to be the lowest ever recorded.

This decrease in mortality is the result of a downward trend in heart and cardiovascular disease. The mortality rates for these two causes decreased 7.5 percent from 1982 to 1987.

Table 7.1

Utilization of Community Hospitals in the United States
(Per 1,000 population)

Year	Beds	Occupancy rates	Average daily census	Admissions
1950	3.4	NA	2.5	111.4
1955	3.5	NA	2.5	117.3
1960	3.6	NA	2.7	129.2
1965	3.9	NA	3.0	138.8
1970	4.2	NA	3.3	145.6
1971	4.3	NA	3.3	148.2
1972	4.3	NA	3.2	150.0
1973	4.3	79.5	3.3	153.2
1974	4.4	77.2	3.3	157.0
1975	4.5	77.4	3.3	158.1
1976	4.5	74.6	3.3	159.1
1977	4.5	73.8	3.3	158.9
1978	4.6	73.6	3.3	158.3
1979	4.5	73.9	3.3	159.2
1980	4.4	75.8	3.3	162.1
1981	4.5	76.0	3.4	161.9
1982	4.5	75.3	3.4	160.2
1983	4.4	73.5	3.3	157.6
1984	4.4	64.8	3.0	151.8
1985	4.3	64.3	2.8	143.1
1986	4.1	64.9	2.7	137.0
1987	4.0	64.9	2.6	132.4

SOURCE: American Hospital Association, *Hospital Statistics* (various annual editions).

Table 7.2

Rate of Discharges and Average Length of Stay for Patients Discharged from Short-Stay Nonfederal Hospitals by Sex, United States, 1987 (Excludes newborn infants)

First listed diagnostic category	Rate of discharges per 1,000 population			Average length of stay (days)		
	Total	Male	Female	Total	Male	Female
All conditions	138.2	116.0	158.9	6.4	6.9	6.1
Heart disease	—	—	—	6.9	6.7	7.2
Malignant neoplasms and carcinoma-in-situ	8.1	7.4	8.1	8.7	9.0	8.3
Benign neoplasms and neoplasms of uncertain behavior	2.1	1.0	3.0	5.4	5.8	5.3
Fractures, all sites	4.4	4.4	4.4	8.9	8.3	9.4
Diseases of the genitourinary system	10.4	8.0	12.6	5.0	5.2	5.0
Pneumonia, all forms	3.8	4.0	3.7	8.0	7.9	8.1
Chronic disease of tonsils and adenoids	1.0	1.0	1.1	1.2	1.2	1.3
Cerebrovascular disease	3.7	3.4	4.0	10.1	9.6	10.4
Diabetes mellitus	2.0	1.7	2.2	7.6	7.7	7.6
Inguinal hernia	1.2	2.3	0.8	2.6	2.5	3.2
Cholelithiasis	2.2	1.3	3.0	7.0	7.6	6.5
Appendicitis	1.1	1.4	0.9	4.7	4.6	4.9

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, *Advancetats*, September 1988.

Table 7.3

Rate of All Listed Surgical Operations for Patients Discharged from Short-Stay Nonfederal Hospitals by Age and Sex, United States, 1987

Age	Rate per 1,000 population		
	Both sexes	Male	Female
Total	138.2	116.0	158.9
Under 15 years	51.3	57.3	45.0
15-44 years	115.1	68.7	160.3
45-64 years	156.9	163.1	151.2
65 years and over	350.5	381.9	329.1

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, "1987 Summary: National Hospital Survey," *Advancetats* No. 158, September 28, 1988.

Table 7.4

Rate of All Surgical Procedures for Inpatients Discharged from Short-Stay Nonfederal Hospitals by Sex, United States, 1987

Procedure	Per 100,000 population		
	Both sexes	Male	Female
All procedures	16,187	13,437	18,767
Operations on the nervous system	378	406	352
Operations on the endocrine system	45	25	64
Operations on the eye	206	193	218
Operations on the ear	93	91	57
Operations on the nose, mouth and pharynx	388	415	362
Operations on the respiratory system	421	513	336
Operations on the cardiovascular system	1,290	1,571	1,025
Operations on the hemic and lymphatic system	165	193	157
Operations on the digestive system	2,418	2,152	2,667
Operations on the urinary system	712	932	506
Operations on the male genital organs	309	639	—
Operations on the female genital organs	1,193	—	2,312
Obstetrical procedures	2,217	—	4,297
Operations on the musculoskeletal system	1,434	1,469	1,402
Operations on the integumentary system	662	570	748
Miscellaneous diagnostic and therapeutic procedures	4,277	4,291	4,264

NOTE: Details may not add to total due to rounding.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, "1987 Summary: National Hospital Discharge Survey," Advance data No. 159, September 28, 1988.

Table 7.5

Proportion of Community Hospitals with Facilities, Services and Special Beds in the United States

Facility	Percent of hospitals				
	1980	1982	1984	1986	1987
Emergency department	82	94	86	95	95
Rehab outpatient	25	33	36	38	41
Family planning	10	11	12	29	32
Open-heart facility	11	11	11	13	14
X-ray therapy	21	20	17	18	18
Megavolt therapy	16	17	15	18	18
Radioact implants	26	23	21	24	24
Organ transplant	—	4	—	5	6
Blood bank	79	72	67	73	71
Respiration therapy	94	91	85	93	92
Speech pathology	43	37	44	50	47
Hemodialysis (inpat)	24	23	24	28	27
Genetic counseling	7	7	8	8	8
Physical therapy	88	88	87	91	88
Occupat therapy	33	36	45	46	45
Psych partial hospital	12	10	14	12	17
Psych outpatient	17	14	21	17	17
Alcohol/chem depend	15	12	18	18	19
Home care depart	12	13	21	35	35
Hospice	6	9	10	15	15
CT scanners	23	31	42	60	60
Nuc mag resonance	—	—	—	10	9

SOURCE: American Hospital Association, *Hospital Statistics*, various issues.

NOTE: By 1987, 55 percent of the hospitals reporting had birthing rooms, 4 percent had extracorporeal shock wave lithotripters, and 70 percent had organized outpatient departments. The 1988 edition of *ANA Hospital Statistics* indicates that 20 percent of community hospitals operated a trauma center in 1987.

Table 7.6

Patients Discharged from Short-Stay Hospitals for Selected Diagnosis and by Age, 1987 (Per 10,000 population)

Diagnosis	Under 15 years	15-44 years	45-64 years	65 years & over	Total
All conditions	512.9	1,151.0	1,568.6	3,505.5	1,381.5
Diseases of the circulatory system	6.0	39.4	385.1	1,121.9	230.6
Heart disease	3.5	21.2	273.1	750.7	154.6
Females/deliveries	2.0	341.3	*	—	161.8
Diseases of the digestive system	56.9	100.1	210.5	425.5	151.6
Injury & poisoning	68.7	120.7	113.7	259.7	125.2
Diseases of the respiratory system	146.3	51.3	118.7	366.1	123.4
Diseases of the genitourinary system	17.1	97.6	127.7	245.7	104.1
Neoplasms	10.8	37.9	177.2	348.5	96.5
Malignant neoplasms	7.3	20.1	145.5	319.5	77.8
Complications of pregnancy, childbirth or puerperium	0.9	78.7	*	—	37.4
Mental disorders	12.3	95.7	79.4	88.3	73.7
Alcohol dependence syndrome	*	18.9	20.3	8.6	13.9

SOURCE: National Center for Health Statistics, 1988.

* Figure does not meet standards of reliability or precision.

Table 7.7

Number of Physician Visits Per Person in the United States, 1987 (All places)

	All ages	Under 18 years	18-44 years	45-64 years	65 years and over
Both sexes	5.4	NA	NA	6.4	NA
Male	4.5	4.2	3.4	5.5	8.5
Female	6.2	4.3	5.9	7.2	9.2

NA = Not available.

NOTE: The data refer to the civilian, noninstitutional population. A "Physician Visit" is a consultation with a physician, in person or by telephone, for examination, diagnosis, treatment or advice.

SOURCE: U.S. Department of Health and Human Services, National Center for Health Statistics, Current Estimates from the National Health Interview Survey, United States, 1987.

Table 7.8

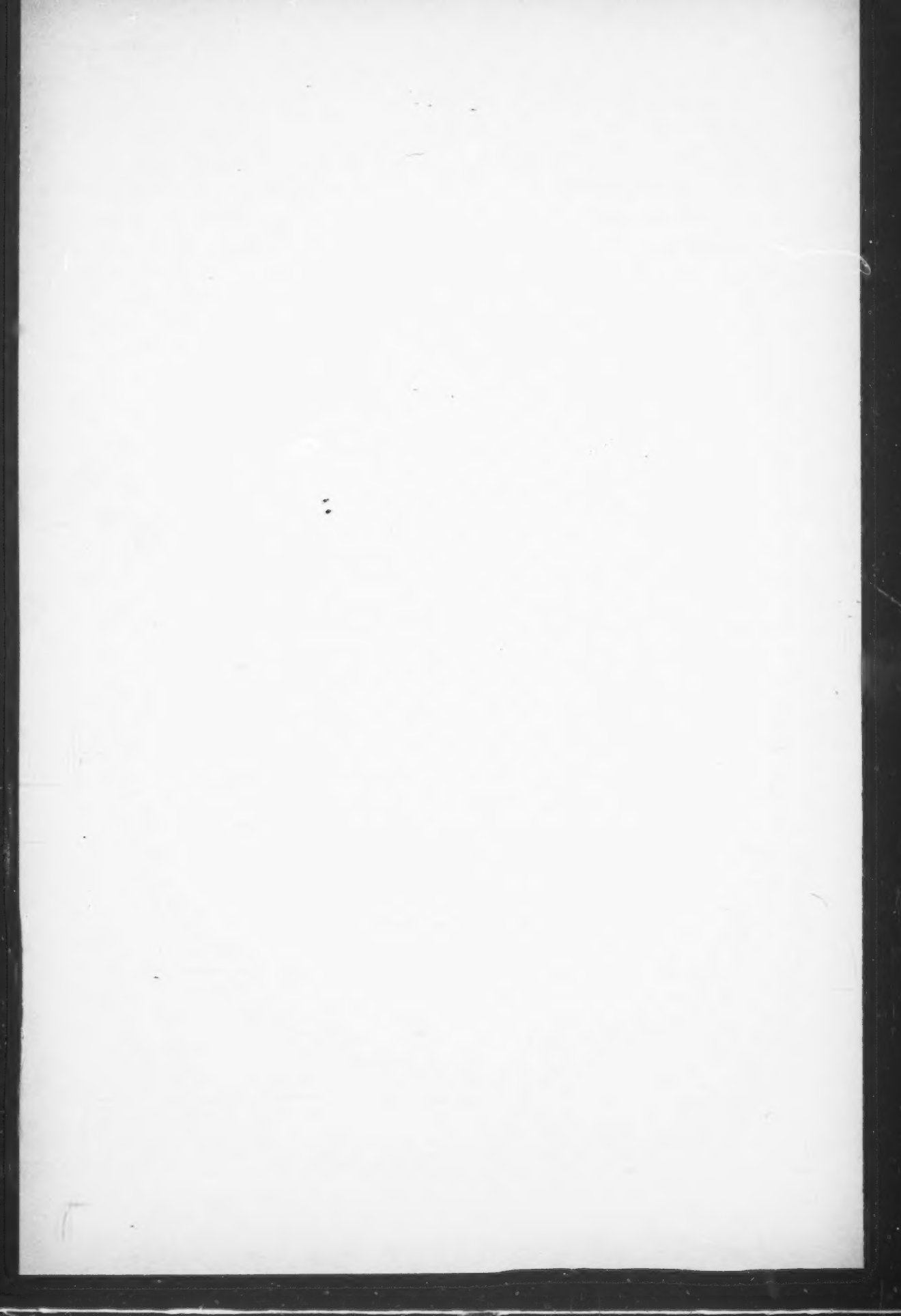
Life Expectation at Various Ages in the United States

Attained age	1984		1985		1986*		1987*	
	Male	Female	Male	Female	Male	Female	Male	Female
0	71.2	78.2	71.2	78.2	71.3	78.3	71.5	78.3
15	57.4	64.2	57.4	64.2	57.5	64.3	57.6	64.3
25	48.2	54.5	48.1	54.5	48.3	54.6	48.4	54.6
35	38.9	44.9	38.9	44.8	39.1	45.0	39.2	45.0
45	29.9	35.5	29.9	35.4	30.1	35.5	30.3	35.5
55	21.5	26.6	21.6	26.5	21.8	26.6	21.9	26.6
65	14.6	18.6	14.6	18.6	14.8	18.6	14.8	18.6
75	9.0	11.8	9.0	11.7	9.1	11.8	9.2	11.8
85	5.2	6.5	5.1	6.4	5.2	6.5	5.2	6.4

* Data are provisional.

NOTE: Some data are revised.

SOURCE: National Center for Health Statistics, U.S. Department of Health and Human Services.



HEALTH AND HEALTH CARE ACRONYMS

ACLI:	American Council of Life Insurance
ADA:	American Dental Association
AD&D:	Accidental Death & Dismemberment Policy
AHA:	American Hospital Association
AIDS:	Acquired immune deficiency syndrome
AMA:	American Medical Association
ANA:	American Nurses Association
APA:	American Pharmaceutical Association
ASO:	Administrative Services Only
BCBS:	Blue Cross-Blue Shield
BLS:	Bureau of Labor Statistics
CDC:	Centers for Disease Control
CHAMPUS:	Civilian Health and Medical Program of the Uniformed Services
COB:	Coordination of Benefits
COBRA:	Consolidated Omnibus Budget Reconciliation Act
CON:	Certificate of Need
CPI:	Consumer Price Index
CPR:	Cardiopulmonary Resuscitation
CPT:	Current Procedural Terminology
DOL:	Department of Labor
DRG:	Diagnostic Related Groupings
EBRI:	Employee Benefit Research Institute
EOB:	Explanation of Benefits
ERISA:	Employee Retirement Income Security Act
FEHBP:	Federal Employees Health Benefits Program
FFS:	Fee for Service
GAO:	General Accounting Office
GNP:	Gross National Product
HCFA:	Health Care Financing Administration
HCPCS:	HCFA Common Procedural Coding System
HHS:	Health and Human Services
HIAA:	Health Insurance Association of America
HIV:	Human Immunosuppressant Virus
HMO:	Health Maintenance Organization
ICD:	International Classification of Diseases
IPA:	Independent Practice Association
LHD:	Local Health Departments
LOS:	Length of Stay

LTC:	Long-Term Care
LTD:	Long-Term Disability
MMPS:	Medical Mortality Prediction System
MPP:	Minimum Premium Plan
NAHDO:	National Association of Health Data Organizations
NAIC:	National Association of Insurance Commissioners
NCHS:	National Center for Health Statistics
NCHSR:	National Center for Health Services Research
NHC:	National Health Council
NIH:	National Institutes of Health
NIMH:	National Institute of Mental Health
OECD:	Organization for Economic Cooperation and Development
PPO:	Preferred Provider Organization
PPS:	Prospective Payment System
ProPAC:	Prospective Payment Review Assessment Commission
SHA:	State Health Agency
SNF:	Skilled Nursing Facility
SSA:	Social Security Administration
STD:	Sexually Transmitted Diseases
STD:	Short-Term Disability
TEFRA:	Tax Equity and Fiscal Responsibility Act
TPA:	Third-Party Administrator
TPP:	Third-Party Payer
UCR:	Usual, Customary and Reasonable
UR:	Utilization Review
WHO:	World Health Organization

HISTORIC DATES

- 1798 U.S. Marine Hospital Service established by U.S. Congress. Compulsory deductions for hospital service were made from seamen's wages.
- 1847 The first insurer to issue sickness insurance was organized: The Massachusetts Health Insurance Company of Boston.
- 1849 New York State passed the first general insurance law.
- 1850s The first insurance supervisory boards were created in New Hampshire, Massachusetts, Rhode Island and Vermont.
- 1850 Individual accident insurance became available in the United States with the chartering of the Franklin Health Assurance Company in Massachusetts.
- 1851 One of the earliest voluntary mutual protection associations, *La Société Française de Bien-faisance Mutuelle*, was organized in San Francisco. It is noteworthy for having established a hospital in 1852 to provide for its members.
- 1855 The first separate insurance department, independent of any established agency, was created in Massachusetts.
- 1859 The first full-time insurance commissioner was appointed in New York.
- 1863 The Travelers Insurance Company of Hartford, Connecticut, offered accident insurance for railway mishaps; then all forms of accident protection. It was the first company to issue insurance on a basis resembling its present form.
- 1875 A number of mutual benefit associations, called "establishment funds," were formed for employees of a single employer. The benefits provided usually included small payments for death and disability.
- 1890s This period brought the promotion of many fraternal associations, assessment mutuals and industrial insurers. Because many of these companies and associations were inadequately financed and poorly managed, many states passed legislation against them.
- 1890 Policies providing benefits for disability from specified diseases were first offered.
- 1900 Shortly after the turn of the century, disability benefits became available for substantially all diseases.
- 1910 Montgomery Ward & Co., Inc., replaced its "employee establishment fund" with an insured contract. This plan is generally regarded as the first group health insurance policy.
- 1912 The Standard Provisions Law drafted by the National Convention of Insurance Commissioners (now the NAIC) was enacted by most states. This model law sought to

- provide uniformity and fairness in the "operating conditions" of the health insurance contract.
- 1916 First noncancelable disability income contract was offered.
- 1917 Group accidental death and dismemberment insurance was first written.
- 1920s Early in this decade individual hospitals began offering hospital expense benefits on an individual prepaid basis.
- 1920s First partial disability benefits for sickness and accident became available.
- 1929 The first health maintenance organization, the Ross-Loos Clinic, was established in Los Angeles, California.
- 1929 A group of school teachers arranged for Baylor Hospital in Dallas, Texas, to provide room and board and specified ancillary services at a predetermined monthly cost. This plan is considered the forerunner of what later became known as the Blue Cross plans.
- 1929 With the Depression, many companies entered a period of retrenchment in their disability income product line, particularly in the area of maintaining reasonable indemnity limits in order to avoid overinsurance.
- 1930s The Depression stimulated the expansion of insurance coverages through both public demand and hospitals' encouragement.
- 1932 First citywide Blue Cross plan was tried out with a group of hospitals in Sacramento, California.
- 1935 The Social Security Act (P.L. 74-241) provided for the first time grant-in-aid to states for such public health activities as maternal and child care, aid to crippled children, blind persons, the aged and other health-impaired persons.
- 1937 Health Service Plan Commission (Blue Cross Commission) was organized.
- 1938 Hospital insurance for dependents of covered persons was developed.
- 1938 Private insurers introduced group surgical expense benefit plans.
- 1939 The first Blue Shield plan (surgical-medical), called the California Physicians' Service, was developed.
- 1940s During World War II, as a result of the freezing of wages, group health insurance became an important component of collective bargaining for employee benefits.
- 1942 Compulsory cash sickness benefits were begun by four states (Rhode Island, 1942; California, 1946; New Jersey, 1948; New York, 1949).
- 1943 Private insurers introduced group medical expense benefits (physician's visits expense benefits).

- 1946 The Health Insurance Council, a federation of eight insurance associations organized to give technical and practical assistance on health insurance to the providers of medical care, was formed.
- 1946 Blue Shield Medical Care Plans, Inc. (Blue Shield Commission) was organized.
- 1948 The National Labor Relations Board ruled, in a dispute between the United Steelworkers' Union and the Inland Steel Company, that the term "wages" be construed to include pension and insurance benefits. The U.S. Supreme Court upheld this ruling in a 1949 decision.
- 1949 Major medical expense benefits were introduced by Liberty Mutual Insurance Company to supplement basic medical care expenses.
- 1954 Congress introduced the disability "freeze" that stated that the quarters during which a worker is disabled are not counted in determining the number of quarters needed to be fully or currently insured under Old Age and Survivors Insurance (OASI).
- 1956 Disability insurance was added to the Social Security System, providing monthly cash benefits for insured persons who are totally disabled.
- 1957 Vision care expense benefits were introduced by private insurers, followed in 1959 by extended care facility expense benefits.
- 1959 Continental Casualty Company issued the first comprehensive group dental insurance plan written by an insurance company.
- 1960s First disability contracts for business use appeared (overhead expense, key man).
- 1960s Eligibility for disability benefits under Social Security was expanded.
- 1961 First state enrollment plan was made available by Connecticut to persons 65 and over on a state basis and under special enabling legislation allowing the pooling of risks by a group of insurance companies (Associated Connecticut Health Insurance Companies).
- 1963 The Health Profession Educational Assistance Act (P.L. 88-129) aided training of physicians, dentists and other public health personnel.
- 1964 Prescription drug expense benefits were introduced.
- 1964 The Nurse Training Act (P.L. 88-581) provided special federal effect for training professional nursing personnel.
- 1965 Social Security Amendments of 1965 (P.L. 89-97) established a Social Security hospital insurance program for the aged and voluntary supplementary medical insurance program (Medicare) and grants to states for medical assistance programs (Medicaid).
- 1966 Program of governmental health insurance, Medicare, for people aged 65 and over, became effective July 1.

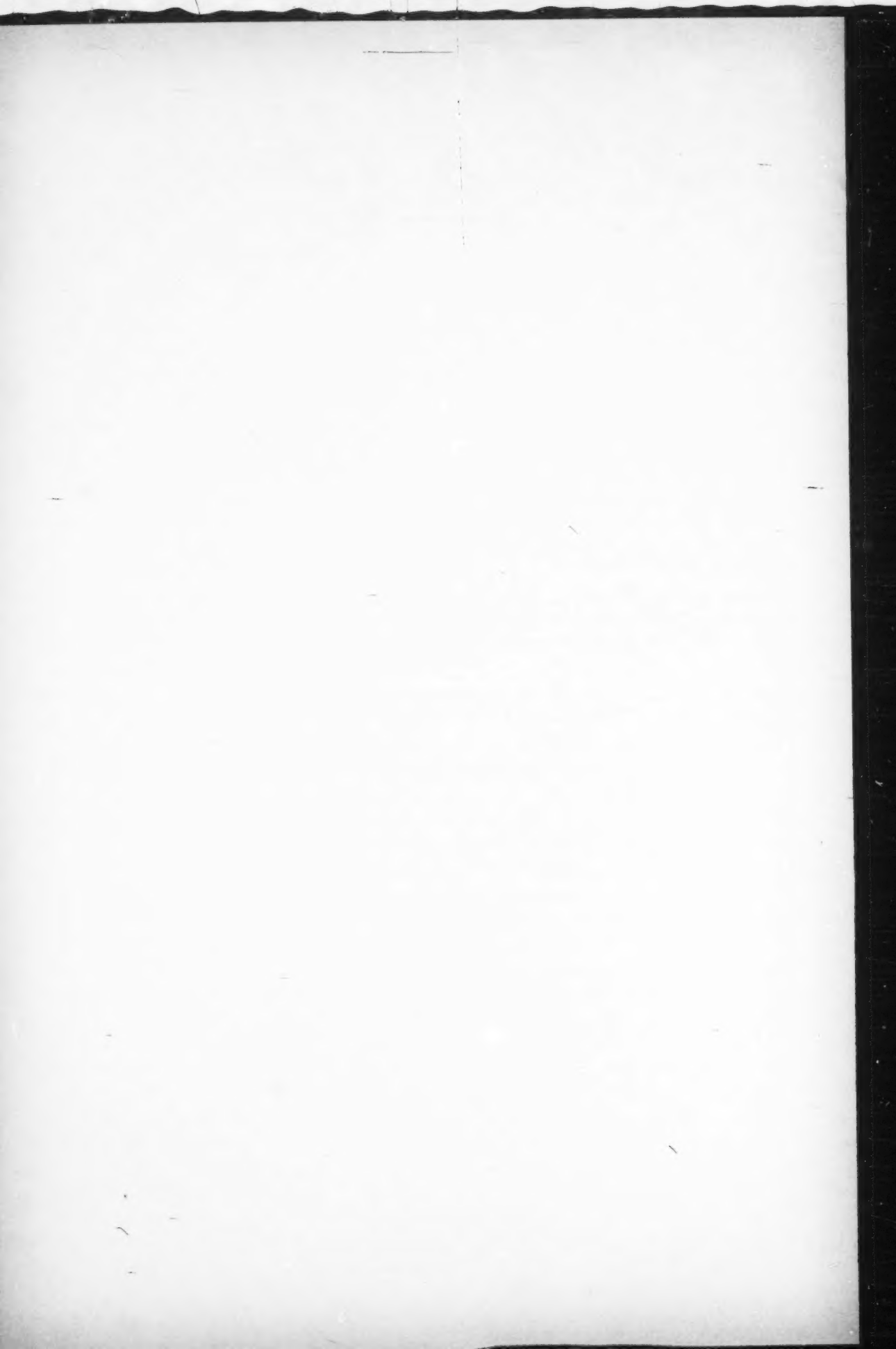
- 1967 The Age Discrimination in Employment Act (DEA) became effective.
- The Act applied only to employees between the ages of 40 and 65, and the vast majority of employee benefit plans provided them with the same benefits as younger employees.
 - The Act contained a specific provision (Section 4(f)(2)) which stated that it was permissible for an employer to observe the terms of any bona fide employee benefit plan such as a retirement, pension or insurance plan which was not a subterfuge to evade the purposes of the Act.
- 1971 The Insurance Medical Scientist Scholarship Fund was formed by several insurance companies, providing full scholarships for students planning careers in medical research and teaching.
- 1972 Social Security Amendments of 1972 (P.L. 92-603) extended health insurance benefits (Medicare) to the disabled and to end-stage renal disease patients, established Professional Standards Review Organization (PSRO) programs, expanded research and demonstrations of financing mechanisms and introduced automatic cost-of-living adjustments to disability benefits.
- 1972 Legislation created the Supplemental Security Income program, which federalized categorical public assistance for the aged, blind, and permanently and totally disabled.
- 1973 The Health Maintenance Organization Act (P.L. 93-222) assisted in the establishment and expansion of HMOs.
- 1974 Employee Retirement Income Security Act (ERISA) of 1974 signed into law. While generally thought of as a law that regulates private pension plans, the Act also contains provisions relating to other employee benefit plans that have encouraged the growth of self-insurance.
- 1975 The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) authorized major federal reorganization of health planning programs and set up the national designation of local Health Systems Areas and governing agencies.
- 1976 The Health Professions Educational Assistance Act of 1976 (P.L. 94-484) contained provisions requiring medical school students who receive federal scholarship aid to serve a specified period in rural and inner city areas, and required that medical schools with teaching hospitals provide for a greater proportion of medical residencies in primary medicine.
- 1976 The Health Maintenance Organization Amendments of 1976 (P.L. 94-460) relaxed requirements for HMOs to qualify for federal support.

- 1976 The National Consumer Health Information and Health Promotion Act of 1976 (P.L. 94-317) set forth national goals for health information and promotion and a systematic strategy for their achievement, stressing health education.
- 1977 The Medicare-Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142) amended the Social Security Act to require uniform reporting of financial data by providers; upgraded criminal penalties for fraud under Medicare-Medicaid programs; and amended certain Professional Standards Review Organization (PSRO) provisions.
- 1978 The Health Maintenance Organization Amendments of 1978 (P.L. 95-559) set forth a three-year extension of the HMO assistance program.
- 1978 Title VII of the Civil Rights Act of 1964 was amended to prohibit sex discrimination on the basis of pregnancy for all employment-related purposes.
- 1978 ADEA of 1967 was amended to raise the mandatory retirement age from 65 to 70. The Act prohibits discrimination concerning benefits to older workers. An employer may coordinate benefits with other programs—e.g., Medicare for employees over age 65—provided that total benefits are equivalent to those offered younger workers.
- 1981 The Omnibus Budget Reconciliation Act mandated significant cuts in federal expenditures for health programs, increased Medicare deductibles, removed limit on number of states that can apply for Medicare and Medicaid cost reimbursement waivers and directed the Secretary of HHS to develop a model prospective reimbursement methodology for inpatient services under Medicare and Medicaid.
- 1982 Tax Equity and Fiscal Responsibility Act of 1982 provided Medicare recognition for any state hospital cost control system that meets certain federal standards, including equitable treatment of all payers; for employees age 65-69 with employer-sponsored health insurance; made Medicare secondary payer; brought federal employees under Medicare and made certain changes in the methods of hospital reimbursements under Medicare.
- 1983 In response to the requirement of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, a prospective payment system for hospital care of Medicare enrollees was enacted as a component of the Social Security Amendments of 1983.
- 1984 Omnibus Deficit Reduction Act of 1984 (P.L. 98-369) extended Medicare as secondary payer of aged spouses of workers

- under 65, froze Medicare reimbursement for physician fees and reduced increases in hospital costs.
- 1984 National Organ Transplant Act of 1984 (P.L. 98-507) established a task force on organ transplantation, authorized grants for organ procurement organizations and established bone marrow registry demonstration and study.
- 1985 Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) required that employer group health plans offer continued coverage to workers and their dependents upon termination of employment, and to workers' spouses and dependents who would lose such coverage due to death of the worker, divorce and Medicare eligibility; made private employer health plans primary to Medicare for active workers and their spouses who also have Medicare coverage; required that third-party payers reimburse for certain care rendered in government-run veterans and military hospitals; and established a task force to study long-term care insurance policies.
- 1986 Tax Reform Act of 1986 (P.L. 99-514) removed the federal tax exemption for Blue Cross-Blue Shield organizations engaged in providing commercial-type insurance, established uniform non-discrimination rules for group health insurance plans and restored a partial, 25 percent tax deduction for health insurance premiums for self-employed individuals and their employees.
- 1986 Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) made private employer health plans primary to Medicare for beneficiaries eligible by reason of permanent disability in cases where the disabled person is a covered dependent under a working spouse's health plan or if the disabled person returns to active employment and revised the formula for determining Medicare's Part A deductible.
- 1986 ADEA for 1967 was further amended to prohibit mandating retirement at any age; employer-provided benefits for older workers must be equal to younger workers'.
- 1988 The Health Maintenance Organization Amendments of 1988 (P.L. 100-51) provide greatly enhanced flexibility to federally qualified HMOs for structuring their organization and for calculating premiums. Employers are also permitted to base their contributions to federally qualified HMOs on the projected claims experience of employees joining the HMO.
- 1988 The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) represents the largest expansion in the Medicare program since its inception in 1965. Benefit changes include the elimination

of all cost sharing for inpatient hospital care after the hospital deductible, a cap on out-of-pocket expenses for physicians' services of \$1,370 and minor changes in skilled nursing, home health and respite care benefits. A phased-in outpatient drug benefit will be added to Medicare in 1991. Employers offering retiree health benefits to Medicare beneficiaries must rebate in cash or new benefits the actuarial value of the new catastrophic benefits for one year.

- 1988 Congress passes AIDS-related legislation containing funds for research, education, HIV testing and home health demonstration project.



GLOSSARY

Accident. An event or occurrence which is unforeseen and unintended.

Accidental Bodily Injury. Injury to the body as the result of an accident.

Accumulation Period. A specified period of time, such as 90 days, during which the insured person must incur eligible medical expenses at least equal to the deductible amount in order to establish a benefit period under a major medical expense or comprehensive medical expense policy.

Actuary. A person professionally trained to apply probability and statistics to the practical problems of insurance and related fields. He/she may specialize in life insurance, health insurance (long-term disability and medical), property and casualty insurance, pension work, government programs or a combination of these. His/her responsibilities include calculation of premiums, policy values, reserves and dividends, preparation of statistical studies and forecasting of financial results. Because of his/her broad training an actuary often has administrative and executive responsibilities.

Administrative Services Only (ASO) Plan. An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group.

Adverse Selection. The tendency of persons with poorer than average health expectations to apply for, or continue, insurance to a greater extent than do persons with average or better health expectations.

Age Limits. Stipulated minimum and maximum ages below and above which the company will not accept applications or may not renew policies.

Agent. An insurance company representative licensed by the state who solicits, negotiates or effects contracts of insurance, and provides service to the policyholder for the insurer.

Aggregate Indemnity. The maximum dollar amount that may be collected for any disability, period of disability or under the policy.

AIDS. Acquired immune deficiency syndrome. A fatal, incurable disease caused by a virus that can damage the brain and destroy the body's ability to fight off illness. AIDS poses major problems for insurers, policyholders and the whole of society.

Allocated Benefits. Benefits for which the maximum amount payable for specific services is itemized in the contract.

Alternate Delivery Systems. Health services provided in other than an inpatient, acute-care hospital. Examples include skilled and intermediary nursing facilities, hospice programs and home health care. Alternate delivery systems are designed to provide needed services in a more cost-effective manner.

Ambulatory Care. Medical services that are provided on an outpatient (nonhospitalized) basis. Services may include diagnosis, treatment and rehabilitation.

Amendment. A formal document changing the provisions of an insurance policy signed jointly by the insurance company officer and the policyholder or his authorized representative.

Application. A signed statement of facts requested by the company on the basis of which the company decides whether or not to issue a policy. This then becomes part of the health insurance contract when the policy is issued.

Approval. (1) Word used in connection with the filing of policy and certificate forms and rates with the state insurance department. (2) A word used in connection with the underwriting process of an insurance company and consists of the acceptance of the risk as set forth in the application as made or modified by the insurer. (3) Acceptance of an offer from an applicant or policyholder in the form of a contract for new insurance, reinstatement of a terminated policy, request for a policy loan, etc., by an officer of the company.

Assignment. The signed transfer of benefits of a policy by the owner of the policy to a third party.

Association Group. A group formed from members of a trade or a professional association for group insurance under one master health insurance contract.

Beneficiary. The person designated or provided for by the policy terms to receive the proceeds upon the death of the insured.

Benefits. The amount payable by the insurance company to a claimant, assignee or beneficiary under each coverage.

Binding Receipt. A receipt given for a premium payment accompanying the application for insurance. If the policy is approved, this binds the company to make the policy effective from the date of the receipt.

Blanket Contract. A contract of health insurance affording benefits, such as accidental death and dismemberment, for all of a class of persons not individually identified. It is used for such groups as athletic teams, campers, travel policy for employees, etc.

Blanket Medical Expense. A provision which entitles the insured person to collect up to a maximum established in the policy for all hospital and medical expenses incurred without any limitations on individual types of medical expenses.

Blue Cross. An independent, non-profit membership corporation providing protection on a service basis against the cost of hospital care in a limited geographical area.

Blue Shield. An independent, non-profit membership corporation providing protection on a service basis against the cost of surgical and medical care in a limited geographical area.

Broker. A sales and service representative who handles insurance for clients, generally selling insurance of various kinds and for several companies.

Business Insurance. A policy which primarily provides coverage of benefits to a business as contrasted to an individual. It is issued to indemnify a business for the loss of services of a key employee or a partner who becomes disabled.

Capitation. A method of payment for health services in which a physician or hospital is paid a fixed, per capita amount for each person served regardless of the actual number of services provided to each person.

Certificate of Insurance. A statement of coverage issued to an individual insured under a group insurance contract, outlining the insurance benefits and principal provisions applicable to the member.

Claim. A demand to the insurer for the payment of benefits under the insurance contract.

Coinurance. A policy provision frequently found in major medical insurance, by which both the insured person and the insurer share the covered losses under a policy in a specified ratio, i.e., 80 percent by the insurer and 20 percent by the insured.

Comprehensive Major Medical Insurance. A policy designed to give the protection offered by both a basic and a major medical health insurance policy. It is characterized by a low deductible amount, a coinsurance feature and high maximum benefits.

Consideration. One of the elements for a binding contract. Consideration is acceptance by the insurance company of the payment of the premium and the statement made by the prospective policyholder in the application.

Contributory. A group insurance plan issued to an employer under which both the employer and employee contribute to the cost of the plan. Seventy-five percent of the eligible employees must be insured. (See Noncontributory.)

Conversion Privilege. A privilege granted in an insurance policy to convert to a different plan of insurance without providing evidence of insurability. The privilege granted by a group policy is to convert to an individual policy upon termination of group coverage.

Coordination of Benefits (COB).

The specific term used to designate the antiduplication provision designed by the group health insurance industry through the Health Insurance Association of America (HIAA) to limit benefits for multiple group health insurance in a particular case to 100 percent of the expenses covered and to designate the order in which the multiple carriers are to pay benefits.

Cost Containment. The control or reduction of inefficiencies in the consumption, allocation or production of health care services that contribute to higher than necessary costs.

Covered Expenses. Hospital, medical, and miscellaneous health care expenses incurred by the insured that entitle him/her to a payment of benefits under a health insurance policy. Found most often in connection with major medical plans, the term defines, by either description, reasonableness, or necessity to specify the type and amount of expense which will be considered in the calculation of benefits.

Deductible. The amount of covered charges incurred by the protected person which must be assumed or paid by the insured before benefits by the insurance company become payable. A deductible is most commonly used in major medical policies; however, it may also be incorporated in base plan policies.

Diagnosis-Related Groups (DRGs).

System that reimburses health care providers fixed amounts for all care

given in connection with standard diagnostic categories.

Disability. Physical or mental handicap resulting from sickness or injury. It may be partial or total. (See Partial Disability; Total Disability.)

Disability Income Insurance. A form of health insurance that provides periodic payments to replace income when an insured person is unable to work as a result of illness, injury or disease.

Dismemberment. Loss of body members (limbs), or use thereof, or loss of sight due to injury.

Double Indemnity. A policy provision usually associated with death, which doubles payment of a designated benefit when certain kinds of accidents occur.

Dread Disease Insurance. Insurance providing an unallocated benefit, subject to a maximum amount, for expenses incurred in connection with the treatment of specified diseases, such as cancer, poliomyelitis, encephalitis and spinal meningitis.

Duplication of Benefits. Overlapping or identical coverage of the same insured under two or more health plans, usually the result of contracts of different insurance companies, service organizations or prepayment plans; also known as multiple coverage.

Earned Premium. That portion of a policy's premium payment for which the protection of the policy has already been given. For example, an insurance company is considered to have earned 75 percent of an annual premium after a period of nine months of an annual term has elapsed.

Effective Date. The date on which the insurance under a policy begins.

Eligibility Date. The date on which an individual member of a specified group becomes eligible to apply for insurance under the [group life or health] insurance plan.

Eligibility Period. A specified length of time, frequently 31 days, following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence of insurability.

Eligible Employees. Those members of a group who have met the eligibility requirements under a group life or health insurance plan.

Elimination Period. A period of time between the period of disability and the start of disability income insurance benefits, during which no benefits are payable. (See Waiting Period.)

Enrollment Card. A document signed by an employee as notice of his/her desire to participate in the benefits of a group insurance plan.

Evidence of Insurability. Any statement of proof of a person's physical condition and/or other factual information affecting his/her acceptance for insurance.

Exclusions. Specific conditions or circumstances listed in the policy for which the policy will not provide benefit payments.

Experience. A term used to describe the relationship, usually expressed as a percent or ratio, of premium to claims for a plan, coverage or benefits for a stated time period.

Experience Rating. The process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience.

Experience Refund. A provision in most group policies for the return of premium to the policyholder because of lower than anticipated claims.

Family Expense Policy. A policy which insures both the policyholder and his/her immediate dependents (usually spouse and children).

Flat Schedule. A type of schedule in group insurance under which everyone is insured for the same benefits regardless of salary, position or other circumstances.

Franchise Insurance. A form of insurance in which individual policies are issued to the employees of a common employer or the members of an association under an arrangement by which the employer or association agrees to collect the premiums and remit them to the insurer.

Fraternal Insurance. A cooperative type of insurance provided by social organizations for their members.

Geographic Divisions (in the United States)

NORTHEAST

New England: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Middle Atlantic: New Jersey, New York, Pennsylvania

MIDWEST

East North Central: Illinois, Indiana, Michigan, Ohio, Wisconsin

West North Central: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota

SOUTH

South Atlantic: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia

East South Central: Alabama, Kentucky, Mississippi, Tennessee

West South Central: Arkansas, Louisiana, Oklahoma, Texas

WEST

Mountain: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

Pacific: Alaska, California, Hawaii, Oregon, Washington.

Grace Period. A specified period after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

Group Contract. A contract of insurance made with an employer or other entity that covers a group of persons identified as individuals by reference to their relationship to the entity.

Guaranteed Renewable Contract.

A contract that the insured person or entity has the right to continue in force by the timely payment of premiums for a substantial period of time, during which period the insurer has no right to make unilaterally any change in any provision of the contract, while the contract is in force, other than a change in the premium rate for classes of policyholders.

Health Insurance. Protection which provides payment of benefits for covered sickness or injury. Included under this heading are various types of insurance such as accident insurance, disability income insurance, medical expense insurance, and accidental death and dismemberment insurance.

Health Maintenance Organization

(HMO). An organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment. The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies and hospital-medical plans.

Hospice. Health care facility providing medical care and support services such as counseling to terminally ill persons.

Hospital Expense Insurance. Health insurance protection against the cost of hospital care resulting from the illness or injury of the insured person.

Hospital Indemnity. A form of health insurance which provides a stipulated daily, weekly or monthly indemnity during hospital confinement. The indemnity is payable on an unallocated basis without regard to the actual expense of hospital confinement.

Hospital Medical Insurance. A term used to indicate protection which provides benefits for the cost of any or all of the numerous health care services normally covered under various health care plans.

Incontestable Clause. An optional clause which may be used in noncancellable or guaranteed renewable health insurance contracts providing that the insurer may not contest the validity of the contract after it has been in force for two (sometimes three) years.

Incurred Claims. Incurred claims equal the claims paid during the policy year plus the claim reserves as of the end of the policy year, minus the corresponding reserves as of the beginning of the policy year. The difference between the year end and beginning of the year claim reserves is called the increase in reserves and may be added directly to the paid claims to produce the incurred claims.

Indemnity. Benefits paid in a predetermined amount in the event of a covered loss.

Individual Insurance. Policies which provide protection to the policyholder and/or his/her family. Sometimes called Personal Insurance as distinct from group and blanket insurance.

Injury Independent of All Other Means. An injury resulting from an accident, provided that the accident was not caused by an illness.

Insurable Risk. The conditions that make a risk insurable are (a) the peril insured against must produce a definite loss not under the control of the insured, (b) there must be a large number of homogeneous exposures subject to the same perils, (c) the loss must be calculable and the cost of insuring it must be economically feasible, (d) the peril must be unlikely to affect all insureds simultaneously and (e) the loss produced by a risk must be definite and have a potential to be financially serious.

Insurance. Protection by written contract against the financial hazards (in whole or in part) of the happenings of specified fortuitous events.

Insurance Company. Any corporation primarily engaged in the business of furnishing insurance protection to the public.

Insuring Clause. The clause which sets forth the type of loss being covered by the policy and the parties to the insurance contract.

Integration. A coordination of the disability income insurance benefit with other disability income benefits, such as Social Security, through a specific formula to insure reasonable income replacement.

Key-Man or Key-Person Health Insurance. An individual or group insurance policy designed to protect a firm against the loss of income resulting from disability of a key employee.

Lapse. Termination of a policy upon the policyholder's failure to pay the premium within the time required.

Legal Reserve. The minimum reserve which a company must keep to meet future claims and obligations as they are calculated under the state insurance code.

Level Premium. A premium which remains unchanged throughout the life of a policy.

Lifetime Disability Benefit. A benefit to help replace income lost by an insured person as long as he/she is totally disabled, even for a lifetime.

Limited Policy. A contract which covers only certain specified diseases or accidents.

Long-Term Care. The continuum of broad-ranged maintenance and health services to the chronically ill, disabled or retarded. Services may be provided on an inpatient (rehabilitation facility, nursing home, mental hospital), outpatient or at-home basis.

Long-Term Disability Income Insurance. Insurance issued to an employer (group) or individual to provide a reasonable replacement of a portion of an employee's earned income lost through serious and prolonged illness or injury during the normal work career. (See also Integration.)

Major Medical Insurance. Health insurance to finance the expense of major illness and injury. Characterized by large benefit maximums ranging up to \$250,000 or no limit, the insurance, above an initial deductible, reimburses the major part of all charges for hospital, doctor, private nurses, medical appliances, prescribed out-of-hospital treatment, drugs and medicines. The insured person as coinsurer pays the remainder.

Manual Rate. The premium rate developed for a group insurance coverage from the company's standard rate tables normally referred to as its rate manual or underwriting manual.

Medicaid. State programs of public assistance to persons regardless of age whose income and resources are insufficient to pay for health care. Title XIX of the federal Society Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.

Medicare. The hospital insurance system and the supplementary medical insurance for the aged created by the 1965 amendments to the Social Security Act and operated under the provisions of the Act.

Medigap. A term sometimes applied to private insurance products that supplement Medicare insurance benefits.

Minimum Group. The least number of employees permitted under a state law to effect a group for insurance purposes; the purpose is to maintain some sort of proper division between individual policy insurance and the group forms.

Minimum Premium Plan (MPP). An arrangement under which an insurance carrier will, for a fee, handle the administration of claims and insure against large claims for a self-insured group.

Miscellaneous Expenses. Expenses in connection with hospital insurance, hospital charges other than room and board, such as X-rays, drugs, laboratory fees and other ancillary charges. (Sometimes referred to as Ancillary Charges.)

Morbidity. The incidence and severity of sicknesses and accidents in a well-defined class or classes of persons.

Multiple Employer Trust (MET). A legal trust established by a plan sponsor that brings together a number of small, unrelated employers for the purpose of providing group medical coverage on an insured or self-funded basis.

National Association of Insurance Commissioners (NAIC). The association of insurance commissioners of various states formed to promote national uniformity in the regulation of insurance.

Noncancellable Guaranteed Renewable Policy. An individual policy which the insured person has the right to continue in force until a specified age, such as to age 65, by the timely payment of premiums. During this period, the insurer has no right to unilaterally make any changes in any provision of the policy while it is in force.

Noncontributory. A term applied to employee benefit plans under which the employer bears the full cost of the benefits for the employees. One hundred percent of the eligible employees must be insured.

Nondisabling Injury. An injury which may require medical care, but does not result in loss of working time or income.

Nonoccupational Policy. Contract which insures a person against off-the-job accident or sickness. It does not cover disability resulting from injury or sickness covered by Worker's Compensation. Group accident and sickness policies are frequently nonoccupational.

Nonparticipating Insurance. Plan of insurance under which the policyholder is not entitled to share in the dividend distribution of the company.

Nonprofit Insurers. Persons organized under special state laws to provide hospital, medical or dental insurance on a nonprofit basis. The laws exempt them from certain types of taxes.

Occupational Hazards. Occupations which expose the insured to greater than normal physical dangers by the very nature of the work in which the insured is engaged, and the varying periods of absence from the occupation, due to the disability, that can be expected.

Optionally Renewable Contract. A contract of health insurance in which the insurer reserves the right to terminate the coverage at any anniversary or, in some cases, at any premium due date, but does not have the right to terminate coverage between such dates.

Overhead Insurance. A type of short-term disability income contract that reimburses the insured person for specified, fixed monthly expenses, normal and customary in the operation and conduct of his/her business or office.

Partial Disability. The result of an illness or injury which prevents an insured from performing one or more of the functions of his/her regular job.

Participating Insurance. Insurance issued by an insurance company providing participation in dividend distribution.

Physician's Expense Insurance. Coverage which provides benefits toward the cost of such services as doctor's fees for nonsurgical care in the hospital, at home or in a physician's office, and X-rays or laboratory tests performed outside the hospital. (Also called Regular Medical Expense Insurance.)

Policy. The legal document issued by the company to the policyholder, which outlines the conditions and terms of the insurance; also called the policy contract or the contract.

Policy Term. That period for which an insurance policy provides coverage.

Preexisting Condition. A physical and/or mental condition of an insured which first manifested itself prior to the issuance of his/her policy or which existed prior to issuance and for which treatment was received.

Preferred Provider Organization (PPO). An arrangement whereby a third party payer contracts with a group of medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients.

Premium. The periodic payment required to keep a policy in force.

Prepaid Group Practice Plan. A plan under which specified health services are rendered by participating physicians to an enrolled group of persons, with a fixed periodic payment in advance made by or on behalf of each person or family. If a health insurance carrier is involved, a contract to pay in advance for the full range of health services to which the insured is entitled under the terms of the health insurance contract. Such a plan is one form of Health Maintenance Organization (HMO).

Principal Sum. The amount payable in one sum in the event of accidental death and in some cases accidental dismemberment.

Professional Review Organization (PRO). An organization in which practicing physicians assume responsibility for reviewing the propriety and quality of health care services provided under Medicare and Medicaid.

Proration. The adjustment of benefits paid because of a mistake in the amount of the premiums paid or the existence of other insurance covering the same accident or disability.

Prospective Payment. An advancement of payment for health care charges that are likely to occur.

Qualified Impairment Insurance. A form of substandard or special class insurance, which restricts benefits for the insured person's particular condition.

Reasonable and Customary Charge. A charge for health care, which is consistent with the going rate or charge in a certain geographical area for identical or similar services.

Recurring Clause. A provision in some health insurance policies, which specifies a period of time during which the recurrence of a condition is considered a continuation of a prior period of disability or hospital confinement.

Rehabilitation. (1) Restoration of a totally disabled person to a meaningful occupation, (2) a provision in some long-term disability policies that provides for continuation of benefits or other financial assistance while a totally disabled insured is retraining or attempting to resume productive employment.

Reinstatement. The resumption of coverage under a policy which has lapsed.

Reinsurance. The acceptance by one or more insurers, called reinsurers, of a portion of the risk underwritten by another insurer who has contracted for the entire coverage.

Renewal. Continuance of coverage under a policy beyond its original term by the insurer's acceptance of the premium for a new policy term.

Residual Disability Benefits. A provision in an insurance policy that provides benefits in proportion to a reduction of earnings as a result of disability, as opposed to the inability to work full-time.

Rider. A document which amends the policy or certificate. It may increase or decrease benefits, waive the condition of coverage or in any other way amend the original contract.

Risk. Any chance of loss.

Self-Administration. The procedure where an employer maintains all records regarding the employees covered under a group insurance plan.

Self-Insurance. A program for providing group insurance with benefits financed entirely through the internal means of the policyholder, in place of purchasing coverage from commercial carriers.

Senior Citizen Policies. Contracts insuring persons 65 years of age or over. In most cases these policies supplement the coverage afforded by the government under the Medicare program.

Short-Term Disability Income Insurance. The provision to pay benefits to a covered disabled person as long as he/she remains disabled up to a specified period not exceeding two years.

Social Security Freeze. A long-term disability policy provision which establishes that the offset from benefits paid by Social Security will not be changed regardless of subsequent changes in the Social Security law.

Special Risk Insurance. Coverage for risks or hazards of a special or unusual nature.

Standard Insurance. Insurance written on the basis of regular morbidity underwriting assumption used by an insurance company and issued at normal rates.

Standard Provision. Those contract provisions generally required by state statutes until superseded by the uniform policy provision.

Standard Risk. A person who, according to a company's underwriting standards, is entitled to insurance protection without extra rating or special restrictions.

State Disability Plan. A plan for accident and sickness, or disability insurance required by state legislation of those employers doing business in that particular state.

State Insurance Department. A department of a state government whose duty is to regulate the business of insurance and give the public information on insurance.

Substandard Insurance. Insurance issued with an extra premium or special restriction to those persons who do not qualify for insurance at standard rates.

Substandard Risk. An individual who, because of health history or physical limitations, does not measure up to the qualification of a standard risk.

Surgical Expense Insurance. Health insurance policies, which provide benefits towards the physician's or surgeon's operating fees. Benefits may consist of scheduled amounts for each surgical procedure.

Surgical Schedule. A list of cash allowances attached to the policy, which are payable for various types of surgery, with a maximum amount based upon the severity of the operation.

Third-Party Administration.

Administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

Time Limit. The period of time during which a notice of claim or proof of loss must be filed.

Total Disability. An illness or injury which prevents an insured person from continuously performing every duty pertaining to his/her occupation or engaging in any other type of work. (This wording varies among insurance companies.)

Travel Accident Policy. A limited contract covering only accidents while an insured person is traveling, usually on a commercial carrier.

Unallocated Benefit. A policy provision providing reimbursement up to a maximum amount for the cost of all extra miscellaneous hospital services, but not specifying how much will be paid for each type of service.

Underwriter. The term as generally used applies to either (a) a company which receives the premiums and accepts responsibility for the fulfillment of the policy contract; (b) the company employee who decides whether or not the company should assume a particular risk; (c) the agent who sells the policy.

Underwriting. The process by which an insurer determines whether or not and on what basis an application for insurance will be accepted.

Unearned Premium. That portion of the paid premium applying to the unexpired portion of the policy term; or that portion of the paid premium for which protection has not been received.

Uninsurable Risk. One not acceptable for insurance due to excessive risk.

Waiting Period. The length of time an employee must wait from his/her date of employment or application for coverage, to the date his/her insurance is effective.

Waiver. An agreement attached to a policy which exempts from coverage certain disabilities or injuries which are normally covered by the policy.

Waiver of Premium. A provision included in some policies which exempts the policyholder from paying the premiums while an insured is totally disabled, during the life of the contract.

Worker's Compensation. Insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured, and to pay benefits to dependents of employees killed in the course of or arising out of their employment.

Written Premiums. The entire amount of premiums due in a year for all policies issued by an insurance company.

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Health Insurance Association of America
1025 Connecticut Ave., N.W.
Washington, D.C. 20036-3998